A CONSTRUCTION OF A CHAPLAIN'S MODE OF MINISTRY CONSISTENT WITH INTERDISCIPLINARY TEAM APPROACH

A Professional Project

Presented to

the Faculty of the

School of Theology at Claremont

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Ministry

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by

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May 1979

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This professional project, completed by

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has been presented to and accepted by the Faculty of the School of Theology at Claremont in partial fulfillment of the requirements for the degree of

DOCTOR OF MINISTRY

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ABSTRACT

The physical facility, organizational structure and the present mode of ministry at the VA Medical Center, Brentwood tend to isolate the chaplain from the heart of the patient's treatment programs and from other professional team members.

The purpose of this study is to construct a more effective chaplain's mode of ministry at Brentwood so that the chaplain may function as an integral part of the treatment team. The author assumed that this goal could be reached by more active participation of the chaplain as a member of the interdisciplinary team.

The term "interdisciplinary team" was defined, then the trend in team approach was examined by considering its historical development and exploring several influences which have created a favorable climate for greater participation of chaplains in interdisciplinary team work.

Next, the types of teams, characteristics of teams, composition of teams, major tasks of teams, and, additionally, structure of teams were investigated to determine the potential of a chaplain's participation as a team member. Furthermore, the feasibility of the chaplain's role adaptation at Brentwood was assessed by considering some of the factors which influence the capabilities of the chaplain to function as a team member. These factors were: (1) the chap-

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lain's orientation in terms of traditional vs. clinical roles; (2) organizational structure of the total institution; (3) attitudes of the administration, staff, and patients; (4) the chaplain's qualification, and training, and his working and social relationships to other professional staff members.

A separate chapter focused on a theology of ministry to help the chaplain realize the uniqueness of his chaplain's role and to help him make his ministry relevant to the patients of contemporary society.

Subsequently, the present mode of ministry at Brentwood was evaluated with data gathered by interviewing randomly selected staff members and all chaplains, using a questionnaire. Based on the information obtained by these data, literature, and personal experiences, the author arrived at the following conclusions: (1) The chaplain should further expand his ministry into clinical roles. (2) The chaplain should become an active member of the Extended Team by task negotiation with the team members on each ward. (3) The chaplain should maintain a close working relationship with other team members for successful integration into the team by continuous personal and professional communication. (4) The chaplain should focus his mode of ministry to the tasks of the team.

Finally, a new chaplain's mode of ministry was con-

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structed around the five tasks of the team based on the evaluation of the present mode of ministry.

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Chapter 1

INTRODUCTION

PURPOSE

The purpose of this study is to evaluate the present chaplain's role at the VA Medical Center, Brentwood, and to construct a more effective mode of ministry in line with interdisciplinary team approach.

PROBLEM

The chaplaincy in VA health care facilities is a specialized ministry which challenges the dedication, skills, creativity and imagination of the chaplain.

Invariably, any dedicated chaplain will find ample work in his ministry to the patients. He can fill up all his time in the performance of his traditional ministerial duties. However, if he limits himself to the performance of traditional roles, he will begin to find himself working at the periphery and isolated from other professional staff members. Besides the type of role in which a chaplain chooses to function, there are other factors which may have the effect of isolating the chaplain from the heart of the health care programs.

One of these factors is the size of the hospital. The larger it is the more wards there are with their own

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programs and team organizations. In this kind of multi-program and multi-unit setting a chaplain finds it difficult to do a meaningful job, and begins to feel frustrated and helpless.

An honest evaluation of his mode of ministry becomes a necessity, especially in view of the emphasis placed on interdisciplinary team efforts in patient care and treatment in VA health care facilities. A chaplain who is sincere and conscientious about his work would not hesitate to assess his role, and would construct a mode of ministry in line with interdisciplinary team approach so that he may effectively fulfill his functions as a chaplain.

METHODOLOGY

For this study, numerous articles published in professional journals and studies relative to interdisciplinary team concept comprised the primary source of materials. In addition to these materials, firsthand experiences, observations and structured interviews with other staff members strengthened and enriched the findings from the literature in this field.

In order to accomplish the task of finding how the chaplains may work as members of the interdisciplinary team, a course of research was pursued with the basic assumption that a chaplain may best fulfill his role when he partici-

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pates significantly as a member of the ward treatment team.

The term "interdisciplinary team member" was defined, then the trend in team approach was examined by considering its historical development and exploring several influences which have created a favorable climate for a change in the extent and nature of the chaplain's participation as a team member.

Next, the organization, functions, characteristics and types of interdisciplinary teams were investigated to determine the nature and potential of a chaplain's participation as a team member. Furthermore, the feasibility of role adaptation of a chaplain as a team member was examined by considering the traditional vs. clinical roles. This was followed by considering several factors which influence the chaplaincy role such as, total hospital organizational structure, attitudes of administration, the qualification and training of the chaplain, and the manner in which staff members and patients perceived the chaplaincy role.

A separate chapter focused on the theology of ministry in order to examine its relevance to the mode of ministry this study purports to construct.

The subsequent portion of the research was devoted to the establishment of norms and criteria growing out of previous studies and experience elsewhere in team approaches.

These criteria were then used to evaluate the present status of team participation by the chaplains. This

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evaluation was aided by the structured interviews of chaplains and other interdisciplinary team members of the medical center.

After this preparatory groundwork was laid, a more effective mode of ministry was constructed consistent with interdisciplinary team approach based on knowledge and information gained from the study.

DEFINITIONS

The definitions of the term "interdisciplinary team" are crucial to this study as they determine the nature of the interdisciplinary approach, and the resultant chaplain's role this research purports to establish. Therefore, this study will attempt at the onset to define the terms.

Review of literature relative to the subject under investigation revealed that the term "interdisciplinary team" is loosely used, and there are as many definitions as there are studies on this subject. Weaver says "definitions have ranged from entire community as psychiatric team, to the general practitioner as a one-man team."[1] An example of a global kind of definition used by Bonn and Kraft is that which includes all who are actively engaged in promot-

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[1]Dale P. Weaver, "the Organization of Psychiatric Teams in a Veterans Administration Mental Hygiene Clinic" (unpublished MSW thesis, University of California, Los Angeles, 1975), p. 61.

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ing the health and welfare of the patient, such as doctors, nurses, adminitrators, dietitians, social workers, chaplains, occupational therapists, etc.[2]

It was also apparent that the definitions vary according to certain factors which are emphasized in defining the term. The definitions of Bonn and Kraft is relevant to a multi-unit psychiatric hospital where the emphasis is on every member of the professional staff within a specific unit of the hospital. In the study of Wise, however, the function of the team which determined the staff composition was emphasized in the definition.[3] A definition by Bowen and his colleagues revised by the author is as follows:

> A team is an integrated group of professionals representing varied disciplines and believing in the principle that a total unit is greater than the sum, who work interdependently and complementarily to attain a common goal by maintaining personal and professional communication and sharing of information.[4]

This definition best fits the author's concept of of interdisciplinary team approach. It is consistent with

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[2]E. M. Bonn and A. M. Kraft, "The Fort Logan Mental Health Center: Genesis and Development," Journal of the Fort Logan Mental Health Center, I (January 1963), 17.

[3]Harold Wise, "The Primary-Care Health Team," Archives of Internal Medicine, CXXX (September 1972), 438-444.

[4]W. T. Bowen and others, "The Psychiatric Team 'Myth and Mystique'," American Journal of Psychiatry, CXXII (December 1965), 17.

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the thesis and rationale of this research; therefore it is assumed whenever the term "interdisciplinary team" is used.

Traditional roles are used synonymously with core-ministerial roles. Clinical roles are not synonymous with non-traditional activities. The term non-traditional activities is used in a broader sense to include chaplain's activities in therapy, administration, education, and consultation. Clinical roles are functions performed by chaplains on the wards, such as 1) Participation in the staff conferences for planning, treatment and disposition of patients, 2) Participation in diagnostic conferences, 3) Participation in community meetings, 4) Participation as a primary therapist, and 5) Participation as a group therapist or co-therapist.

REVIEW OF LITERATURE

This section will describe a review of the literature covering studies which have contributed significantly to the author's research and to the author's construction of a model of ministry consistent with interdisciplinary team approach.

The studies reviewed are categorized as follows: (1) Organization and Functions of Interdisciplinary Team, and (2) Role-Functions of Chaplain.

Organization and Functions of Interdisciplinary Team

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On the matter of criteria for interdisciplinary teams Horwitz discussed and described at length integration and coordination as opposite poles of a continuum.[5] Weaver investigated the factors which need improvements to achieve a more functional team operation at the Mental Hygiene Clinic, VA Medical Center, Brentwood. His findings indicated that there were three prerequisites for effective team development as the team of psychiatrists, social workers, a clinical nurse and a human service worker progressed through the stages of structuralization, unrest, change and integration. These were (1) conflict resolution, (2) continuous personal and professional communication, and (3) task negotiation.[6]

Bergman described three types of teams which will be discussed at greater length elsewhere in the author's study. She classified them as (1) the Basic Team, (2) the Extended Team and (3) the Consultative Team.[7]

Role-Functions of Chaplain

In 1964 the role of the chaplain was studied by

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[5]John J. Horwitz, Team Practice and the Specialist (Springfield, Il: Thomas, 1970)

[6]Weaver

[7]Rebecca Bergman, "Typology for Teamwork," American Journal of Nursing, LXXIV, 9(1974), 1618-1620.

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Knights and Kramer at the Cleveland (Ohio) Psychiatric Institute. Of the 15 actual or possible role functions investigated, conducting religious worship and visiting patients were functions of the chaplain perceived positively by more than 90% of both the staff and the patients. The only other function that received such a highly favorable response was that of administering sacraments, which was rated quite positively by the staff but much less positively by the patients. While there was a good acceptance in regard to very limited traditional role-functions, the non-traditional functions which actually made up the bulk of the chaplain's work were not understood and were only nominally accepted.[8]

A study by Gynther and Kempson helps to set forth the role of the chaplain as it is perceived in clinical situations. They reported the results of their study in assessing objectively the attitudes of patients and staff toward the developing chaplaincy program at the South Carolina State Hospital. It was shown that staff in general thought of chaplains as counselors, while patients viewed them as preachers. Education, administration, and evangelism were not seen as being important. There were considerable differ-

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[8]Ward Knights and David Kramer, "Chaplaincy Role-Functions as seen by Mental Patients and Staff," Journal of Pastoral Care, XVIII, 3(1964), 154-160.

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ences within the hospital staff in regard to how the chaplain's activities were perceived. The conclusion was that even though there was general approval of the work of the chaplains, the real motives and goals of the chaplaincy program were often misunderstood.[9]

Manley also surveyed the role expections of staff clergymen in a clinical setting at the Greenville Comprehensive Mental Health Center by staff members and community clergy. The results indicated that the staff clergyman was expected to make unique contributions as a consultant regarding the patient's religious beliefs, practices, and religious support system. He was also expected to contribute to other staff members and local clergymen his understanding and knowledge of the dynamics and resolution of grief, guilt, and healthy and unhealthy religion. He was also expected to initiate an educational program for community clergymen which could extend the center's influence in the community and its effectiveness both in the prevention and treatment of mental illness. Manley's study also affirmed the non-traditional functions of a clergyman in mental health settings including therapy, administration, education, and consultation as vital

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[9]Malcolm D. Gynther and J. Obert Kempson, "Attitudes of Mental Patients and Staff toward a Chaplaincy Program," Journal of Pastoral Care, XIV, 4(1960), 211-217.

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ministry.[10] Concerning the influence of the role expectations of the chaplain by the administrator Golden discovered that chaplains tend to fulfill those functions that administrators expect them to fulfill.[11]

With regard to chaplain's role-definitions Morrow and Matthew surveyed the opinions of 113 chaplains employed full-time in State mental hospitals across the nation as to how broad should be the definition of the chaplain's proper role. The result showed substantial consensus as to general approval of clinical role-activities; rejection of an evangelistic role as inappropriate; and strong approval of core-ministerial activities. Nearly all chaplains reported engaging in some clinical role-activities, with wide variation in the extent and frequency of participation, but more chaplains endorsed each clinical activity than reported engaged in the activity. The study further discovered that nearly all chaplains reported engaging in certain core-ministerial role-activities.[12]

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[10]Wilford C. Manley, "Role Expectations of Clergy in a Mental Health Setting," AMHC Forum, XXIX, 1(1976), 8-17.

[11]Edward S. Golden, "What Influences the Role of the Protestant Chaplain in an Institutional Setting?" Journal of Pastoral Care, XVI, 4(1962), 218-225.

[12]William R. Morrow and Thomas J. Matthews, "Role-Definitions of Mental-Hospital Chaplains," Journal for the Scientific Study of Religion, V, 3(1966), 421-434.

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The contributions of the chaplain to the treatment program can be made most significant when the chaplain is a full participant on the psychiatric team, keeping abreast of and contributing to staff planning, treatment and disposition of patients. This fact was found to be true in the study of Stein and Thomas conducted at the Mendota Mental Health Institute in Madison, Wisconsin. These various contributions which the chaplain made to an intensive adult treatment service where he had a small enough patient load to function as a member of the team were: (1) to the patient's feeling of trust, (2) to helping patients accept their own feelings, (3) to the staff's understanding of the patient's life as revealed through his religious history and practices, (4) as a religious counselor in both one-to-one and in religious discussion group settings, (5) to family interviews, (6) as a bridge to the community and the aftercare of the patient, and (7) as a worship leader for the hospital community.[13]

Summary

Studies categorized under 1) organization and functions of interdisciplinary team provided information on cri-

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[13]Leonard I. Stein and John R. Thomas, "The Chaplain as a Member of the Psychiatric Team," AMHC Forum, XXVII, 3(1975), 106-111.

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teria for, and types of, interdisciplinary teams, and information on three prerequisites for effective team development, which helped to evaluate and improve on the present status of chaplain's team participation at Brentwood. Studies categorized under 2) role-functions of the chaplain described the prevalence of misunderstanding and stereotyped view of chaplain's role-functions by the staff and patients in clinical situations, and the influence of role-expectations of the chaplain by the administrator on chaplain's role functions. These studies indicated the need for the chaplain to reassess his mode of ministry, and suggested that the chaplain needs to function broadly in an integrated way as a team member by including both traditional and non-traditional roles in his mode of ministry. In addition, one study emphasized the fact that the chaplain's contributions to the treatment program can be most significant when he is a full participant on the team.

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Chapter 2

INTERDISCIPLINARY TEAM APPROACH

DEVELOPMENT OF TEAM APPROACH: A HISTORICAL OVERVIEW

The decade of the 1930's marked the beginning of the establishment of psychiatric teams. Weaver[1] gives an excellent historical overview of the development of psychiatric teams within the past five decades. Initially, the neuropsychiatric team was established in several psychiatric outpatient and child guidance clinics. The emphasis was placed on maximizing the use of available staff in carrying out not only their particular functions, but also in contributing something personal to the treatment program.

The employment of psychiatric teams entered its second phase of development during World War II with the emergence of the neuropsychiatric team in the U.S. Army. With the large influx of individuals requiring psychiatric services, it became necessary for psychiatrists, social workers and psychologists to pool their skills in a cooperative effort to resolve an acute shortage of professional psychiatric manpower. Under this method of operation more fre-

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[1]Dale P. Weaver, "The Organization of Psychiatric Teams in a Veterans Administration Mental Hygiene Clinic," (unpublished MSW thesis, University of California, Los Angeles, 1975), pp. 13-55.

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quent interchange of professional opinion was encouraged, which resulted in the development of therapeutic skills, expanded in-service training, and increased research activities.

It was during the second World War that the team became identified as the most effective approach for accomplishing the general tasks of diagnosing and treating psychiatric disturbances. This treatment method was carried on in civilian practice later. The value of employing psychiatric teams for diagnosis and evaluation of mental patients was well demonstrated by this time.

The postwar period saw the prevailing use of psychiatric teams in hospital setting. This was attributed to the increasing specialization among practioner with accelerating need for providing training opportunities, and the shortage of psychiatric services to meet the excessive demand.

At the conclusion of World War II there was a sharp increase in the number of articles published on the subject of psychiatric teams. The literature of the early 1950's dealt essentially with subjective endorsements of the team concept. By 1955, however, emphasis was shifted to a more objective study of team effectiveness and therapeutic impact. The influence of these and later studies of psychiatric team dynamics have had far-reaching professional and social significance in the staffing of psychiatric hospitals and clinics.

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TEAM APPROACH AND CHAPLAINCY

The concept of psychiatric teams in the United States developed at a time when psychiatry, psychology and social work were struggling to achieve identity and recogtion. Clergymen were not usually accepted by these disciplines as being on their peer level. Consequently, clergymen were not included as team members.

Today the climate for clergymen's participation as team members is much more favorable for the following reasons: (1) the improvement of medico-clerical cooperation, (2) trend toward holistic approach, (3) establishment of community mental health centers, and (4) growth of clinical pastoral education.

Medical-Clerical Cooperation

Two noteworthy events believed by the author to have created this favorable climate occured in 1961. The Joint Committee on Mental Illness and Health reported to the Congress early in 1961 regarding the nation's mental health. According to this report one in seven people admitted having sought professional help with problems in living; 42 per cent consulted clergymen; 20 per cent consulted psychiatrists or psychologists; 10 per cent consulted social agencies or marriage clinics. Of those who turned to their clergymen, one out of three were regarded as having problems of serious

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psychiatric dimensions yet only one out 10 was referred for psychiatric attention.[2]

In September of 1961 the Board of Trustees of the American Medical Association established an Advisory Committee on Medicine and Religion, which was composed of 10 physicians and 10 clergymen as the result of realizing the need for communication and cooperation between physicians and clergymen. This committee's purpose was to create an avenue of dialogue between these two disciplines to improve total patient care.[3] However, the underlying force which helped to bring about this era of dialogue was the prevalence of the holistic viewpoint.

The nation has already seen the far-reaching influince of the creation of this Committee of Medicine and Religion in the AMA. Similar committees have been established on the State level, and under their direction and planning programs have been sponsored to bring together physicians and clergymen for professional dialogues.

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[2]Anthony Zappala, "A Joint Venture of Psychiatrists and Clergy: The Pastoral Institute," Medical Annals of the District of Columbia, XXXII, 6(1963), 247.

[3]Paul B. McCleave, "Department of Medicine and Religion of the American Medical Association," Rocky Mountain Association, LX, 11(1963), 27.

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Holistic Viewpoint

According to holistic principles, there are physical, spiritual, emotional and social dimensions to a whole person, and there is a close and complex interrelationships among them. The increasing evidence of psychosomatic problems has been an influential factor in confirming the fact that there is a complex interaction between body, mind and soul and that what affects one affects the other.[4] It is recognized that illness in any one of these parts can create illness in all three factors.

The current movement toward interdisciplinary teamwork in health care facilities is the result of the need to see a person as a whole being, and of the comprehensive approach to the treatment and care of illness based on holistic principles. In a sense, this is a movement back to a primitive time when the healer was a physician, priest, and sorcerer, all in one person. With all these functions vested in him he was able to see a person as a whole being without the limitation of narrow specialization.

With the advent of specialization the healer has lost his unified functions along with the consequent loss of his ability to see the person as an integrated human being.

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[4]James C. Doyle, "Medicine and Religion," California Medicine, CI, 3(1964), 210.

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Specialist-healers as we now know them tend to have limited, specialized functions and fragmented, incomplete view of the person.[5] The treatment and care of the whole person through interdisciplinary team work will correct this unwholesome trend.

Reviving the holistic viewpoint, particularly in the treatment of psychosomatic illnesses, leads to treatment and care of the whole person through interdisciplinary team work. The majority of physicians have recently come to recognize that a patient must be seen within the entire contex of his environment in determining the social, economic, psychological, and physiological factors involved in his/her illness, especially in emotional disorders.[6]

The favorable climate in which chaplains now find themselves presents them with opportunities toward greater involvement as members of the interdisciplinary team.

Community Mental Health Centers

The development of the multidisciplinary team practice has been greatly influenced by the establishment of

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[5]Paul B. McCleave, "Medicine, Religion and the Patient," New Physician, XII, 10(1963), A9.

[6]Alvin J. Straatmeyer and Warren L. Jones, Cooperation Between Clergyman and Physician," South Dakota Journal of Medicine, XX, 9(1967), 36.

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Community Mental Health Center.[7]

According to recent studies conducted by Bloom at the 87 federally-assisted Community Mental Health Centers in 13 Western States, interdisciplinary team approach to delivery of services practiced in these centers are generally felt to have substantial advantages over practices that do not bring the mental health professions together.[8]

In his work published in 1969 Pattison refers to the extent of the chaplain's involvement in 11 model Community Mental Health Centers. His study prompted him to assume that the role of the chaplain in these centers was peripheral and ancillary, although in three centers there was a pastoral consultant for exclusive work with ministers. In the conclusion of his study he advocated the development of roles and functions for a chaplain who would serve as an integral member of the interdisciplinary team of these centers.[9]

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[7]Roy H. Schlachter and others, "Attitudes and Perception of Attitude Change within the Interdisciplinary Staff of an Evening Mental Health Clinic," International Journal of Social Psychiatry, XXI, 3(1975), 195.

[8]Bernard L. Bloom and Howard J. Parad, "Interdisciplinary Training and Interdisciplinary Functioning: A Survey of Attitudes and Practices in Community Mental Health," American Journal of Orthopsychiatry, ILVI, 4(1976), 676.

[9]E. Mansell Pattison, "The Role of Clergymen in Community Mental Health Programs," International Psychiatry Clinics, V, 4(1969), 255.

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Clinical Pastoral Education

Clinical Pastoral Education programs too are believed by the author to have prepared the way for greater participation of chaplains in interdisciplinary team work. Since the introduction of the first clinical training programs for clergymen by Anton Boisen at the Worcester State Hospital in 1925, an extensive network of centers has been established across the nation for the training of seminarians and clergymen. The Associations of the Clinical Pastoral Education dedicated to clinical pastoral training has a national headquarters in New York with approximately 333 training centers in nine regions. ACPE sets up the standards for the three levels of training; namely, basic, advanced and supervisory. It also accredits training programs and certifies supervisors who do the actual training at these centers.[10]

It is customary for each center to have several chaplain trainees at one time assigned to certain units of these centers. They have a chance to function as unit chaplains, and are able to participate in the activities of the units as members of the interdisciplinary team. The exposure to team work in their training experiences have been

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[10]Association for Clinical Pastoral Education, Directory of Accredited Clinical Pastoral Education Centers and Member Seminaries, 1977.

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valuable in orienting the clergymen toward team concept, and in preparing them to become integral members of the interdisciplinary team.

ORGANIZATION OF INTERDISCIPLINARY TEAMS

The following section describes the author's investigation of the types of teams, characteristics of teams, composition of teams, major tasks of teams, and, additionally, structure of teams according to the survey of literature; plus a brief survey of the organization of interdisciplinary teams at Brentwood.

Types of Teams

Bergman describes three types of teams as follows:

1. Basic Team is a group of staff members located at the same ward which permits daily contacts among themselves and with the patients. These staff members carry out the essential functions of the specific ward. The staff members are directly responsible to the physician in charge of the program.

2. Extended Team is made up of the Basic Team supplemented by specialists located elsewhere on the institutional grounds. They participate as needed to help deal with selected aspects of the cases. They report clinically to the physician in charge of the program.

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3. Consultative Team, which consists of the Extended Team supplemented by consultants located elsewhere than on the ward, is set up to deal with a specific problem that is beyond the scope of the Extended Team. The consultant reports clinically to the physician in charge of the program, and provides learning experiences for other team members.[11]

Characteristics of Teams

Horwitz says teams are comprised of varied disciplines because "problems demand a more diversified armamentarium of skills than is possessed by any one profession."[12] Another characteristic of teams is that the accomplishment of the team is greater than the combination of the accomplishment of each team member working independently. This phenomenon is illustrated by Jacobson with the principle that a total unit is greater than the sum of its parts.[13] Another way of stating this is that a team composed of different

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[11]Rebecca Bergman, "Typology for Teamwork," American Journal of Nursing, LXXIV, 9(1974), 1618-1620.

[12]John J. Horwitz, Team Practice and the Specialist (Springfield, Il: Thomas, 1970)

[13]Sylvia Jacobson, "A Study of Interprofessional Collaboration," Nursing Outlook, XXII, 12(1974), 755.

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disciplines is better equipped to see the whole person, and bringing a wide range of skills and knowledge to bear is able to treat the whole being.

Finally, the integration of disciplines in team work does not necessarily sacrifice professional integrity and responsibility. To this point Bloom states, "interdisciplinary practice does not necessarily imply an egalitarian attitude, task assignment or responsibility." Further, he states, "one can be in favor of interdisciplinary functioning while maintaining beliefs in professional specialization and in a hierarchy of professional responsibility."[14]

Composition of Teams

Teams are composed of professionals representing different disciplines, such as psychiatry, social work, psychology, nursing, chaplaincy, dietetic service, physical theraphy. In determining the composition of teams as to the disciplines to be represented, Wise emphasized the function of the team,[15] and Dressler and Nash, those skills required to serve the patient's needs.[16]

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[14]Bloom

[15]Harold Wise, "The Primary-Care Health Team," Archives of Internal Medicine, CXXX (September 1972), 438-444.

[16]David M. Dressler and Kermit B. Nash, "Project Team Organization and Its Application to Crisis Intervention," Community Mental Health Journal, X, 2(1974), 157-158.

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Major Tasks of Team

The function of a team may be delineated into the major tasks of crisis intervention in the treatment and care of patients. According to the study of Dressler and Nash,[17] there are five major tasks of teams. These are (1) the establishment of an interpersonal relationship and crisis intervention, (2) encouraging catharsis of disturbed thoughts and feelings, (3) reduction of symptomatic distress, (4) restoring wholesome relationships with significant others, and (5) developing successful coping mechanisms.

Structure of Team

According to the study of Bowen and his colleagues, every member of the team comes to the team with professional competance, which includes the capacity, freedom, and responsibility to make and carry out prefessional decisions concerning patients. They meet together to communicate and share knowledge from which plans are made and thus future therapeutic decisions are influenced.[18]

The following section describes a brief survey of the organization of interdisciplinary teams at Brentwood.

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[17]Ibid., pp. 156-162.

[18]W. T. Bowen and others, "The Psychiatric Team 'Myth and Mystique'," American Journal of Psychiatry, CXXII (December 1965), 688-90.

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Types of Teams

According to the program survey compiled by the Evaluation/Admission Service at Brentwood (See Appendix A), there were a total of 18 discrete programs on the wards at this Medical Center as of February 1976.

Each program has a Basic Team, and as needs arise Extended Team or Consultative Team is set up. For example, a vocational specialist assigned to several wards participates in the Extended Team to help deal with the vocational aspect of the patient's problem.

Characteristics of Teams

The characteristics of teams at Brentwood are like those described in the literature. In order to treat the whole being and care for the needs of the patient, a team which is made up of professionals representing the varied disciplines can do a better job than any profession by itself or these professionals functioning separately and independently.

Composition of Teams

The composition of teams at Brentwood is determined by the function of the team and those skills required to serve the needs of patients in the particular program. For instance, the kind of staff members needed in an alcoholism treatment program is different from those needed on a general

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psychiatric ward.

Major Tasks of Team

The major tasks of teams at Brentwood are similar to those described by Dressler and Nash. However, they may vary with certain emphases needed for the respective programs. In a geriatric psychiatric ward the emphasis is on support and care because the patients, in general, are not fully functional.

Structure of Team

At this Medical Center the team leader is usually a psychiatrist. Having both administrative and supervisory functions to perform for a particular program, he presides over staff conferences on the ward. The staff members belong to their respective services according to the organizational structure, however, operationally and clinically they are responsible to the team leader.

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Chapter 3

ROLE ADAPTATION OF THE CHAPLAIN

The following section discusses some of the factors which influence the capabilities of chaplains to function as interdisciplinary team members. These factors are: (1) the chaplain's orientation in terms of traditional vs. clinical roles; (2) organizational structure of total institution; (3) attitudes of the administrators, staff and patients; and (4) the chaplain's qualifications and training, and his working and social relationships to other staff.

TRADITIONAL VS. CLINICAL ROLES

It appears that a chaplain who can fulfill both traditional and clinical roles without limiting himself to either one of them is able to participate more fully and can make more valuable contribution to the treatment program. It is the traditional role which gives unique quality to the work of the chaplain, but many of the traditional roles are performed unnoticed by other team members. However, the performance of clinical roles takes the chaplain to the wards, and this visibility aids him in becoming perceived as a team member.

The author believes the chaplain's function ought to encompass both traditional and clinical roles. This view is supported by the work of Morrow and Matthews who investigated

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the chaplains' evaluation of their traditional and clinical roles. Their study was based on a sample of 113 obtained by a questionnaire sent to each of the 301 Protestant chaplains employed full-time in State Hospitals. This figure included 70% of all mental hospital chaplains. The results showed that there was a substantial consensus as to (1) the general approval of clinical role-activities, (2) the rejection of an evangelistic role as inappropriate, and (3) strong approval of core-ministerial activities; in particular, religious counseling and conducting of worship services.

This study also indicated the factors which influence the chaplains either to function, or approve the idea of functioning in broader clinical roles. In accord with the hypothesis, chaplains who approved broader clinical roles were a little less apt to endorse a conventional-authoritarian religious ideology characterized by religious supernaturalism, Biblical literalism, moral absolutism, dependence of man and woman on God and the church, etc., as opposed to a more humanistic outlook. They were also less apt to endorse a custodial mental illness ideology which stresses control and safekeeping of mental patients in contrast to emphasis on treatment , and stereotyped negative concepts of mental patients as opposed to more psychological, optimistic, individualized concepts, etc.[1]

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[1]William R. Morrow and Thomas J. Matthews, "Role-Definitions of Mental- Hospital Chaplains," Journal for the Scientific Study of Religion, V, 3(1966), 421-434.

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PHYSICAL FACILITY AND ORGANIZATIONAL STRUCTURE

Where a health care facility consists of multiple buildings and a multi-ward organizational structure the nature of the participation of the chaplains as members of the interdisciplinary team is affected adversely due to physical separation of chaplains from other staff and patients. This acts to limit the chaplain's availability as a team member, especially as part of a Basic Team. The author found this to be true at VA Medical Center, Brentwood. There are twenty wards situated in six buildings with a program and team organization on each ward. Of course, in this kind of setting the Chaplain Service is not able to staff each ward with a chaplain to serve as a member on the ward's Basic Team due to the limited number of chaplains.

Consideration of other types of interdisciplinary team suggests that it would be more feasible for chaplains to function as members on the Extended Team in this setting. The nature of the Extended Team gives the chaplain the freedom to select the staff meetings he wishes to attend so his participation may help him in his ministry to the patient. As a member of the Extended Team he also has the freedom to attend the team meetings of all the wards he is assigned to. It is preferable for the chaplain to be a member of the Basic Team. However, where this is not possible he can still make valuable contribution as a member of the Extend-

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ed Team or Consultative Team.

The positioning of the Chaplain Service as shown on the chart of the organizational structure influences the way chaplain's functions are perceived by other staff. This also influences the chaplain's status and peer acceptance by other professional disciplines.

Here at Brentwood the positioning on the current organizational chart shows the Chaplain Service is far removed from other clinical professionals and closer to the administrative area. (See Appendix B) Consequently, the chaplain is not likely to be perceived as a clinically integral part of the professional teams who are directly involved with patient care and treatment. Further, he is not likely to be perceived as someone who would have any direct influence on the planning and decision-making of the patient's treatment and care plans or someone whose roles, functions and tasks would contribute directly to the accomplishment of the patient's treatment goals.

Rather, he is perceived more as an adjunct or accessory to the treatment team. That is, the chaplain is regarded as someone who is contributing in a secondary way by helping those who are directly involved in treatment and care of patients. The Chaplain Service is perceived as an adjunct service on an equal par with other nonclinical services, such as Libray, Recreation, Canteen etc. Recently, the positioning of the Chaplain Service on the organizational

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chart has been moved from the Hospital Assistant Director to the Hospital Director. The significance of this move is that the Chaplain Service is farther removed from the other clinical team members. It is believed by the author that such status perception by these clinical professions with whom the chaplain wants to work closely would have an adverse effect on the capability of chaplain to function as a team member.

ATTITUDES OF ADMINISTRATORS, STAFF AND PATIENTS

The capabilities of chaplains to function as members of the team depend to a great degree on whether they function broadly in an integrated way or narrowly in a limited way. The author found this to be true at Brentwood. The chaplain who can function broadly by adding clinical roles to his traditional roles is much better equipped and more capable of functioning as a team member than he who can perform narrowly in mere traditional roles. Important as these broad or narrow functions are, it is the role-expectations of chaplains by hospital administrators which determine whether the chaplains perform broadly or narrowly.

This view is supported by Golden who found in his study that there is a significant correlation between the director's concept of the chaplain's role behaviors with the actual behavior of the chaplain. The correlation anal-

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ysis revealed that those chaplains who were functioning broadly had directors who expected them to function broadly or in an integrated way with the professional staff. On the other hand, those chaplains who were functioning within a narrow concept of role, or were functioning in an ancillary, limited way tended to have directors who expected them to perform only the narrow functions.

The former chaplains were fulfilling their specifically religious functions, but were also participating in the clinical and rehabilitative aspects of the institutional program. The latter group of chaplains were denied, by virtue of their perceived role, an opportunity to participate in the clinical and rehabilitative aspects of their institution's life. They fulfilled the religious tasks but were not integrally related to their institutions and tended to be dissatisfied or received only minimum satisfaction from the ministry.[2]

According to the results of interviews conducted for the author's study at Brentwood the author concluded that the Hospital Director and Assistant Director expect the chaplains to function broadly in an integrated way. Such role-expectations should have a favorable influence on the Brentwood chaplains' capabilities to function as

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[2]Edward S. Golden, "What Influences the Role of the Protestant Chaplain in an Institutional Setting?" Journal of Pastoral Care, XVI, 4(1962), 220-221.

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team members.

The author believes the following developments will give support to the chaplains to function as team members. In Cental Office, Washington, D.C. the Mental Health and Behavioral Science Service was established in 1972, in which were brought together the professions represented in the Psychiatry, Neurology, and Psychology Services plus representation from Nursing Service, Social Work Service, Chaplaincy, and Physical Medicine and Rehabilitation Service. The goal of this Service was to accomplish comprehensive and integrated planning of mental health programs and services for the total VA health care delivery system on a multidisciplinary basis. Since that time, multidisciplinary conferences and workshops have been held throughout the VA.[3]

Furthermore, according to the guidelines provided by the Mental Health and Behavioral Sciences Service, the Mental Health Council is emerging in VA health care facilities as a viable mechanism for the facilitation of multidisciplinary planning and consultation for mental health services. These Mental Health Councils serve to function as a forum, which consists of Chiefs of the various Ser-

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3U.S., VA Chief Medical Director's Letter to Director's of Hospitals, "Creation of Mental Health and Behavioral Sciences Service in Central Office, " IL 10-72-14.

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vices with important mental health missions, namely Psychiatry, Psychology, Social Work, Rehabilitation Medicine, Nursing and Chaplain Services.[4]

The attitudes of the staff and patients toward the role-functions of chaplain also affect his capabilities to function as a team member. When the staff and patients have a stereotyped view of chaplain's role-functions so that they fail to perceive some of his vital nontraditional roles which are appropriate and important for him to perform, the chaplain's ability to function as a team member is diminished.

The acceptance of chaplain's work in the mental hospital is still based on very limited traditional role-functions. The nontraditional functions are not understood and only nominally accepted. This fact was borne out by the study conducted at the Cleveland (Ohio) Psychiatric Institute. Of the fifteen actual or possible role-functions of chaplain investigated only a fifth of these received a highly positive response by more than 90% of both the staff and the patients. These functions were highly traditional ones for clergymen, such as leading religious worship, visiting patients and administering sacraments. Much less favorable

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[4]U.S., VA Professional Service Letter to Directors of VA Hospitals, Domiciliary, Outpatient Clincis and Regional Offices with Outpatient Clinics, "Mental Health Councils," IL 11-76-32.

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ratings were given to the nontraditional functions.[5]

The attitude of patients toward the chaplain affects his capabilities to function as team member. It appears that the patient's religious background will determine his attitude toward the chaplain and his utilization of chaplain service.

This fact was found to be true in Chase' study, which indicated that if the patient had a close relationship to his church as measured by his regularity of attendance he will tend to retain this sense of close relationship to the church while a patient as indicated by his positive response to the hospital chaplain. Basically it meant that prior training and practice in religious participation are essential to the best utilization of religion as a source of strength in time of trouble.[6]

CHAPLAIN'S QUALIFICATION AND TRAINING

The capabilities of the chaplain to function as a

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[5]Ward Knights and David Kramer, "Chaplaincy Role-Functions as Seen by Mental Patients and Staff," Journal of Pastoral Care, XVIII, 3(1964), 154-160.

[6]Phillip Chase and William N. Deane, "Newly Admitted Hospitalized Mental Patients: Their Relationships with the Clergy, Journal of Pastoral Care, XVII, 2(1964), 92-93.

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team member are determined by his qualification and training. Qualification does not refer to the basic professional qualification and training required to be a clergyman, but to that which is essential for him to function as a chaplain in a particular setting of interdisciplinary collaboration.

A competent chaplain needs an important personal qualification. Without it even a clergyman of a successful pastoral background will fail to function in an interdisciplinary setting. This is the ability to work with other professional staff members. Stephanie supports this view by stating, "the effectiveness of the chaplain ultimately will be determined by his personal ability to work with other members of the hospital team ..."[7]

In the author's opinion the chaplain's ability to work with other members implies the capability to enter into interdependent peer relationships. A chaplain who was accustomed to being looked upon as the shepherd of the flock or the leader of the congregation may find it necessary to make some intrapsychic adjustment in order to function as a team member.

It appears that a special training would enhance the chaplain's capabilities to function as team member.

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[7]M. Stephanie, "Chaplain-Hospital Relationship," Hospital Progress, XLII, 5(1961), 156.

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Golden's study conducted elsewhere bears out this fact. His report indicated a significant correlation between what the chaplains were actually doing and their training for this work. The better trained chaplains tended to function broadly, having better relationships with other team members, while the less adequately trained chaplains tended to be performing the narrow functions, having poorer and less meaningful interpersonal relationships with them.[8]

A training program for hospital chaplaincy needs to be conducted in a clinical setting. The cllnical training for chaplaincy which is higly recommended is offered by the Associations of Clinical Pastoral Education. The training will not only give depth and breadth to the chaplain's ministry, but will also help him to work with other professionals.

Though CPE training is highly desirable for chaplaincy, it is not a prerequisite for VA chaplains. The VA chaplains are appointed with varied background and experiences, some with or without CPE training and some with equivalent in experience.

CHAPLAIN'S RELATIONSHIPS WITH OTHER TEAM MEMBERS

The chaplain's relationships with other team members affect his capabilities to function as team members. As a team member the chaplain needs to maintain a close working

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[8]Golden, pp. 221, 22.

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relationship with other team members for successful integration into the team. Here at Brentwood the chaplain is not able to enjoy as close a relationship with other team members as they have with each other.

There are certain factors which may account for the close relationship of the other team members. First is the physical proximity of the office location of these members, which gives them the necessary visibility and the sense of closeness. Second, being situated in the same section of the building they have more opportunities of seeing and talking to each other than otherwise.[9] Third, the sense of belonging is enhanced by being assigned to the same ward and in working for the same patients. Fourth, as members of the Basic Team they regularly participate in ward activities, such as community meetings, diagnostic meetings, staff meetings, working cooperately and sharing in the common goals of the ward.

The chaplains, on the other hand, do not have these opportunities to get acquainted with other team members. For example, their offices are located in a separate building, some distance away from majority of the wards. Moreover, because of the limited number of chaplains they are

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[9]Dale P. Weaver, "The Organization of Psychiatric Teams in a Veteran Administration Mental Hygiene Clinic" (unpublished MSW thesis, University of California, Los Angeles, 1975), 37-38.

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not able to staff the wards and participate in the ward activities as other team members do, but must divide their work among all the wards. Consequently, the chaplains have less sense of belonging and of working together with other team members as a unit to feel part of the ward team. However, these circumstances should not deter the chaplains from their efforts to form good relationships with other team members.

The chaplain must take the initiative in this direction. Of all the team members the chaplain must first establish rapport with the psychiatrist on each ward because he is the program director in the VA Neuro-psychiatric facilities. Also, from the therapeutic and administrative standpoint he is in the best position to familiarize the chaplains with his philosophy of ward treatment programs and team organization.

In the initial orientation of a newly assigned chaplain to a certain ward, the Chief of the Chaplain Service may be of invaluable help by introducing him to the ward psychiatrist. The psychiatrist in turn will introduce the chaplain to other members of the team, such as the nurses, social workers, psychologists, etc.

Following this introduction it becomes the responsibility of the chaplain to become better acquainted with each team member professionally and personally. In a close association with other team members opportunities inevita-

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bly present themselves in getting to know better the contribution of each team member to the total treatment program.

For the purpose of getting acquainted with staff members of the ward team the Brentwood Chaplain Service has initiated an ongoing program whereby each professional staff representing a discipline be invited regularly to the chaplain staff meetings to mutually share their roles as team members with the chaplains. The psychiatrists may wish to use this time to present the treatment program of the ward they represent.

In addition, the Brentwood administration has recently approved the request of the Chaplain Service to include the chaplains in the orientation of newly-employed physicians to the station. This has been followed by a similar approval from the Central Office.[10] The participation of the chaplains in the orientation of psychiatrists is a long-waited innovation at Brentwood. It is believed to help facilitate the get-acquainted process and, in turn, effect better cooperation of these services in an interdisciplinary team working relationships.

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[10]U.S., VA Professional Service Letter to Directors, All VA Medical Center Activities, "Physician and Chaplain Orientation Program," IL 11-78-55.

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Chapter 4

THEOLOGY OF MINISTRY

The following section describes the author's theology of ministry for a chaplain who function in a mental health setting.

Two reasons for the need of a theology of ministry are as follows: First, the chaplain who works as a member of an interdisciplinary team needs a theology of ministry which helps him to realize the uniqueness of the roles he is fulfilling as a chaplain. He works with other professionals who are also of the helping services, so there are times when his performance of his own roles overlaps with those of other team members. However, the chaplain has distinct roles only he can perform because of the nature of his ministerial calling. A theology of ministry will help him to be aware of and not to lose sight of his unique functions.

Second, the chaplain needs a theology of ministry which helps him to make his ministry relevant to the patients of contemporary society. He ministers in a society where, for many individuals, Christianity has become an ideology and man is all too prone to be skeptical about its relevance to his life experiences.[1] However, the author believes that

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[1]Henri J. M. Nouwen, The Wounded Healer (Garden City: Doubleday, 1972), p. 12.

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the chaplain can make his ministry relevant to the patients at the VA Medical Center, Brentwood so that Christianity is meaningful for life today. A theology of ministry will help the chaplain to understand the essence of Christianity which has made life meaningful for people through all the ages of mankind. The author believes that such theology of ministry has a solid Biblical and theological base.

FUNDAMENTAL PRINCIPLE

Ministry to others is the fundamental principle for Christian living. The perfect example of ministry was set forth by Christ in His service to human beings here on the earth through His labor of love, in teaching, healing and deeds of compassion, and even to the point of suffering and death. Referring to His ministry Christ said, He "did not come to be served; he came to serve and to give His life to redeem many people."[2] He also stated, "I am among you as one who serves."[3] The profound significance of Christ's ministry was that He examplified ministry not by merely teaching an ideology, but by offering Himself to the service of mankind.

The importance of becoming servants to each other is implied in Christ's statement, "Whoever would be great

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[2]Mk. 10:45. [3]Lk. 22:27.

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among you must be your servant."[4] Christ also stated how we may become servants to each other by saying, "As I loved you, that ye also love one another."[5] Christ "was to reveal to human beings divine love through labor of love so their hearts would be touched by the tender mercy of God and producing spontaneously this divine charity in their dealing with their fellows."[6]

God's plan for humanity is to fully reveal His love to human beings in a tangible and concrete manner so they would be able to love Him and their fellow human beings. This is God's mission to humanity, and God calls His servants to fully identify with His plans through their devotion to this cause.

SIGNIFICANCE OF THE TERM "SERVANT"

The name "servant of God" in the Bible is a title of honor. God calls those who fully identify with His plan through their life and work His servants.

The title is given to those whose mission it is to serve God's chosen people in helping them to be faithful to the service which He expects of them. For example, it often

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[4]Mt. 20:27. [5]Jn. 13:34.

[6]T. W. Manson, The Servant-Messiah (Cambridge: University Press, 1956), p. 59.

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refers to Moses, the mediator of the covenant, and to Joshua who leads the people into the promised land of Canaan. It also applies to the prophets who have the mission of maintaining the covenant, as well as to the priests who conduct divine worship services. The honorable title is also applied to the entire nation of Israel which had a mission from God to perform to all the nations.

In the fullest sense of this word, "the Servant of God" is employed in the four sections of Isaiah called Songs of the Servant, referring to the Messiah whose mission it is to fulfill God's plan for mankind.

The New Testament shows how Christ demonstrated through His life of service what it means to be the Servant of God. Even today Christ's disciples who fully identify with God's cause for mankind through their lives of devotion are called the servants of God. The work of His servants still involves helping His followers to remain faithful to the service God expects them to perform.

"SERVANT" IN THE OLD TESTAMENT

In the Old Testament the application of the Hebrew term עֶבֶד for "servant" is fourfold. First, the patriarchs, prophets and kings were called God's servants in the sense of being the chosen agents of God. For example, characters

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such as Abraham,[7] Isaiah,[8] and Solomon[9] were individually addressed as a "servant" of God.

Second, the term is also used of the nation of Israel in the Old Testament, especially in Isaiah 41-66 where it frequently refers to Israel as God's servant.

Another application of the term is to the Messiah, who is depicted as the "suffering servant" of Isaiah 52:13-53:12.

Finally, the word indicates one who is an adherant of Yahweh. In such usage, the emphasis is on the individual subject who comprises the nation of Israel. Each Gentile who joins Israel in worshiping the Yahweh[10] is also considered His servant.

MINISTRY OF THE MESSIAH AND ISRAEL

Head of Israel

The individual and collective use of the term "servant" implies the inseparable connection between the four types of servants described above. The close connection between the servant as applied to the Messiah and the servant as referred to Israel becomes prominent especially in Isaiah 40-66. The close connection between the Messiah and

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[7]Ps. 105:42. [8]Is. 20:3. [9]1 Ki. 1:26. [10]Is. 56:6.

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Israel also signifies their close relationship, which is substantiated by the fact that the Messiah is Israel's "maker" and "husband."[11] The accomplishment of the Servant's mission to Israel and to the world was contingent upon the full cooperation on the part of Israel with His mission. As God's chosen people they had an integral role to play as His servant so that they might become a light to the Gentiles and mediate His saving work to the ends of the earth. Von Rad recognized the theological cross-connection between the servant Messiah on the one hand and Israel on the other, and said the boundaries between these are fluid at certain points, and that much of what Isaiah says about Israel is used in the Songs of the Servants of the Lord to refer to the Messiah.[12]

Ministry of the Messiah

There are four passages, which are called the Songs of the Servant of the Lord: Isa. 42: 1-4; 49:1-6; 50:4-9; 52:13-53; in them the election, ministry, and suffering of the Servant are set forth in an altogether distinctive way. These poems may justly be regarded as constituting the most important section in the Old Testament for the light that

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[11]Is. 54:5.

[12]Gerhard Von Rad, Old Testament Theology (New York: Harper & Row, 1965), II, 259-60.

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they throw upon the significance of the ministry and suffering and death of Jesus. It was to these passages that the early apostolic witnesses turned as they sought in their preaching and writing to interpret the meaning of these events in the life of Christ.

A study of the Servant passages leads to a consideration of the covenant that God made with Israel. It is in the Servant that the full meaning of the covenant is gradually revealed; it became embodied in a human personal life in the Servant of the Lord, who is the mediator of the covenant for the people. In fact, the Servant becomes the covenant itself or the embodiment of the covenant.

In a special sense the Messiah Himself was to be the "servant" of the Lord, completing the spiritual restoration and glorification of the Israelites after their return from Babylonian captivity. This work still proceeds and will reach a certain climax in the coming of the Messiah, who, through His saving function, namely His ministry, and His vicarious suffering and death, will provide deliverance from the bondage of sin which causes the separation of people from God and from each other.

MINISTRY IN THE NEW TESTAMENT

Christ the Perfect Servant of God

The saving work and function of the Servant as

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described in the Messianic Prophecy of the book of Isaiah were fulfilled in the ministry, vicarious suffering, and death of Christ on this earth.

Christ took upon Himself the form of a servant,[13] and ministered to mankind, teaching, preaching, and healing to save them from sin. He fulfilled in His life of service the prophecy concerning His saving work. Relative to its fulfillment Luke recorded the incident when Jesus, after reading the words of Isaiah 61:1-2, and delivery of a sermon in the synagogue, stated, "This day is this scripture fulfilled in your ears."[14]

Christ also realized in His life and death the idea of the Servant of God suffering and dying for the sins of mankind. The Synoptics saw in Jesus Christ the fulfillment of the Messianic Prophecy of the suffering Servant as recorded in the book of Isaiah.[15]

Saving Work of Christ

A component of Christ's saving work was to preach the gospel (εὐαγγελίζω) to the poor (πτωχός). In Isaiah 61:1 it is to tell the good tidings (בָּשַׂר) to the meek,

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[13]Phil. 2:7. [14]Lk. 4:21.

[15]Mt. 8:17; Mk. 9:12; Mk. 15:28; Lk. 22:37.

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poor, or afflicted (עָנִי). The poor refer not only to those in unfavorable circumstances from an economic point of view, but also those who are conscious of their needs of something more than this world has to offer. Sometimes, through reverses in life God prepares hearts, and makes them receptive to the preaching of the Gospel.

Another aspect of His saving work was to heal (ἰάομαι) the brokenhearted (συντετριμμένος την καρδίαν). In Isaiah 61:1 it is to bind up (חָבַשׁ) instead of to heal. The brokenhearted were the broken, beaten, worn out or crushed as to the heart. There were many in Jesus' time, as well as today, who are worn out physically, mentally, and emotionally. The imagery is of someone who needs divine healing. However, Christ heals because He is the physician (ἰατρός) of those who are sick.[16]

MINISTRY OF CHRIST COMPARED TO MODERN MINISTRY

The purpose of Christ's ministry as God's Servant was to reveal God's love to mankind so that men and women would respond in love to Him and to their fellow human beings. He accomplished this by being emotionally close to the people He ministered to and living among them.

He entered into their lives and shared their fears,

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[16]Mat. 9:12.

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anxieties, sadness, troubles, despair and feelings of alienation. Of course, the happiest time for Him was when He could share in their joyous occasions. This intimate acquaintance with and participation in their experiences enabled Him to focus and minister to their physical, spiritual and emotional needs. This stirred up His compassion for them to the extent that it resulted in His performance of miracles to meet these needs.

He came so close to the people that He was able to guide them into a more fulfilled life. This was the result of knowing what to preach and teach and by using pertinent illustrations and parables gathered from life situations.

No matter what moral condition He found the people in He accepted them just as they were, without censure or condemnation. This resulted in the repentance and conversion of many sinners.

Christ identified completely with humankind and shared in their experiences to the extent of vicariously suffering and dying for their salvation. Thus, He was to reconcile men and women to Himself and to each other. Additionally, through His life of vicarious suffering and death, God through Christ revealed to us that He will be with us in life and death.

The purpose of the modern ministry of God's servant is to reveal God's love to his fellow human beings so as to enable them to love God supremely and their fellow men and

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women more fully. The modern minister accomplishes this by maintaining close and intimate relationships with those he ministers to.

He enters into their lives and shares in their life experiences whether they be of anxieties, fears, sadness, troubles, despair or happiness and joy. By getting acquainted with them and participating in these experiences, he learns what their physical, spiritual and emotional needs are and discovers how to minister to these needs. He is then able to guide them into a more fulfilled life by not only teaching and preaching but by his example. When he lives close to them he knows what themes are relevant to their lives, and is able to draw pertinent illustrations from their life situations.

No matter what moral condition he finds the people in he must accept them just as they are, without censure or condemnation in order to discover a basis for future changes. This will help the people to gain confidence in him, and will open up opportunities for specific spiritual and moral guidance.

The modern minister needs to have compassion for people even as Christ had for those who had dire spiritual, physical and emotional needs. This helps him to be more accepting, understanding, and loving to them.

The more he can give himself in service to his fellow human beings, even as Christ gave Himself, the more effec-

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tive his ministry can be. To make his ministry relevant for contemporary society he must be a living document of love even as Christ became an incarnate love among men and women.

INTEGRAL ROLE OF THE CHURCH

The church is a body of people who believe in Jesus as the Messiah and who accept Him and His teachings, and who are joined to this organization originated by Him. It is also considered the body of Christ comprised of God's servants.

The head of the body or the church is Christ Himself,[17] and the people who make up the church are the members of the body.[18] As members of the body of Christ the servants are all one in Christ Jesus.[19] The necessity of maintaining a connection with Christ as an essential qualification of God's servants is indicated by the illustration of the vine and the branches.[20]

As the church submits to the saving function of Christ she is in turn to serve the world as God's servant in helping men and women to respond to the plan of salvation. The work the church is called to perform is the same that Jesus had described as His own when He said, "The

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[17]Eph. 5:23. [18]1 Cor. 12: 27. [19]Gal. 3:28.

[20]Jn. 15:1-8.

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Spirit of the Lord is upon Me, because He hath anointed Me to preach the gospel to the poor; He hath sent Me to heal the brokenhearted, to preach deliverance to the captives, and recovering of sight to the blind, to set at libery them that are bruised."[21]

The church carries out the saving work of Christ by teaching and preaching the gospel (kerygma), by establishing a fellowship borne of Christ's love (koinonia), by implementing the faith in loving service (diakonia).

The ultimate objective of the church is the "increase among men of the love of God and neighbor,"[22] in the church and in the world. For this purpose God has given to the church apostles, prophets, evangelists, pastors, and teachers "for the perfecting of the saints, for the work of the ministry, for the edifying of the body of Christ: till we all come in the unity of the faith, and of the knowledge of the Son of God, unto a perfect man, unto the measure of the stature of the fullness of Christ: ..."[23]

In the New Testament the term "servant" applies to these ministers of the gospel, who are unconditionally obliged to serve the Christians. For example, Paul,[24]

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[21]Lk. 4:18.

[22]H. Richard Niebuhr and others, The Purpose of the Church and Its Ministry (New York: Harper & Brothers, 1956), p. 31.

[23]Eph. 4:11-13. [24]Ro. 1:1.

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James,[25] and Timotheus,[26] were called the servants of Jesus Christ. These servants are not only to serve the church but are called for the work of the ministry (πρὸς τὸν καταρτισμὸν τῶν ἁγίων εἰς ἔργον διακονίας) that is, to prepare the saints for practical services. In carrying forth the saving work of Christ the ministers are the directors,[27] leading out the church in saving the world.

MINISTRY OF THE AUTHOR

The author specializes in the performance of loving service (diakonia) of the church in the hospital setting.

In a sense, he is also the director of Christ's saving work in a setting other than the church in that he sets an example of ministry before the staff and patients, of which some are Christians. Furthermore, he leads out in the saving work of making a person whole physically, mentally and spiritually.

According to Clebsch there are four functions of a chaplain, namely healing, sustaining, guiding and reconciling.[28] The fulfillment of these functions makes the author an instrument of God's healing and growth, a channel

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[25]Jas. 1:1. [26]Phil. 1:1.

[27]Niebuhr and others, p. 83.

[28]William A. Clebsch and Charles R. Jaekle, Pastoral Care in Historical Perspective (Englewood Cliffs: Prentice-Hall, 1964), pp. 8-10.

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of His liberating love.

Plummer emphasizes the clergyman's role and task of reconciliation.[29] The author believes that reconciliation has been already provided in Christ; the chaplain is simply the agent by whom "the work of reconciliation" is proclaimed to patients. Through his functions as chaplain he leads the patient into the presence of God where he experiences reconciliation for himself.

The ultimate objective of the author's chaplaincy is increasing the ability of men and women to love God and their neighbors. A mental patient who is emotionally disturbed is unable to establish mutually need-satisfying relationships because he or she is blocked or crippled in their ability to love deeply. Therefore, any performance of these tasks which help the patient "find release from the captivity of their neurosis, overcome their alienation, increase their capacity to love, and renew their relationships"[30] is a fulfillment of this objective.

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[29]Stuart A. Plummer, "Thoughts Regarding the Role of a Clergymen," Rocky Mountain Medical Journal, LXV, 1(1968), 76.

[30]Howard J. Clinebell, Jr., Basic Types of Pastoral Counseling (Nashville: Abingdon Press, 1966), p. 47.

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Chapter 5

EVALUATION OF THE PRESENT STATUS OF TEAM PARTICIPATION BY CHAPLAINS

PRESENT MODE OF MINISTRY

The following section briefly describes the chaplain's present mode of ministry at Brentwood. It is a modified version of the Brentwood Chaplain Service Operational Procedure[1] adapted for the use of this study. The operational details were added at places to complete the format.

"The philosophy of the Chaplain Service is to help an ill person accept himself and believe that he is indeed a creature of worth. This is a vital aspect of patient care. Religion, with its values, prayers, and rituals can serve as a motivating force in convincing the individual that despite his limitations, he is a worthwhile human being. The chaplain, as minister of his faith, can play an important role in this area.

"To provide an objective ministry through organization, administration, programs, and procedures to all patients and personnel at this Medical Center. The primary mission is to provide for the spiritual and moral welfare of the patient. To accomplish this mission, in conformity with

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[1]VA Medical Center, Brentwood, Chaplain Service "Operational Procedure," January 24, 1979.

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the mission of the Medical Center, a program of religious ministry twenty-four hours a day, seven days a week, has been established.

"This program includes:

a. Conduct religious services, such as divine worship services and special Holy Days and Communion Services.

b. Ministry to and regular visitation of critical and serious-ill patients.

c. Visitation and ministry to newly-admitted patients within the first two days of admission if at all possible.

d. Regular ward visitation and counseling of patients and staff on assigned wards.

e. Participation in staff or group meetings on assigned wards when possible.

f. Ministry and/or counseling of patients, relatives and friends, especially during instances such as the serious illness or death of a patient.

g. Funeral services, on a scheduled basis, at the Los Angeles VA National Cemetery.

h. Attendance at special staff meetings and conferences with the overriding aim of better patient care.

i. The Chief, Chaplain Service, is directly responsible to the Medical Center Director for the administrative and functional operation of the Service.

j. Individual chaplains are responsible to the patients, ward staffs and the Chief of the Service for an adequate and efficient ministry on their assigned wards, using their own techniques and expertise.

k. Serve, in turn, as night duty "on call" chaplain according to the roster prepared monthly by the Chief of Service. This period of duty covers the time frame from 4:30 p.m. until 8:00 a.m. the following day.

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1. Administer sacraments or rites required by their denominations. Any decision to baptize any patient should be discussed thoroughly with the patient's doctor. Marriage involving a Brentwood patient should not be encouraged. The matter will be discussed thoroughly with the patient's doctor. Normally a marriage involving a Brentwood patient would be referred to a civilian clergyman after the patient's discharge from the hospital."

RATIONALE

In any task of evaluation it is essential to use a uniform measuring instrument for obtaining reliable and valid results. This principle applies to the evaluation of chaplains' team participation done at Brentwood. The evaluation instrument in this case was a questionnaire (See Appendix D) developed for interview purposes, and included the following items:

1. What is your concept of the role of a chaplain?

The first item on the questionnaire pertained to the person's concept of chaplains, or their ideas of chaplains, as expressed in terms of their roles. The author believed this concept is critical because it influences the way the staff perceive the chaplain's role and the way the chaplain perceives his role.

2. Which of the following definitions of interdisciplinary team best fit your concept of interdisciplinary team approach?

   a. A term which includes all who are actively engaged in promoting the health and welfare of the patient, such as doctors, nurses, administrators, dietitians, social workers, occupational therapists, etc.

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b. A term to designate every member of the professional staff within a specific unit of the hospital.

c. The process whereby various professionals who make individual decisions concerning patients and who share a common purpose, meet together to communicate and share knowledge from which plans are made and thus future therapeutic decisions are influenced.

The questionnaire also listed three definitions of "interdisciplinary team" from which each interview participant was asked to choose one which best fits his concept of interdisciplinary team work. According to the author the choice of definition is critical for two reasons. First, it influences whether chaplains are perceived as team members by other staff members. For example, a staff member will not consider chaplains as team members if he saw their roles out of harmony with his choice of definition. Second, the choice of definition determines the chaplain's role-functions and the staff members' role-expectations of chaplains. For example, chaplains who believe in a global kind of definition probably will not perform clinical roles. And, the staff who believes in the third definition which emphasizes communication and sharing in staff meetings will expect chaplains to attend these meetings.

3. Do you consider the chaplains as members of the interdisciplinary team? Yes____ No ____

4. If no, please give reasons.

This question revealed whether those interviewed perceive the chaplains as team members. Those who answer-

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ed negatively were asked to state their reasons because the author felt the negative responses would be more valuable in helping the chaplains with their self-assessment.

5. Which of the following three types of interdisciplinary teams do you consider the chaplains are members of?

   a. Basic
   b. Extended
   c. Consultive

Another item on the questionnaire was a list of three types of teams from which each person interviewed was asked to choose one he felt the chaplains belong to. The author believes these responses will help the chaplain understand which types of team meetings the staff expect him to attend.

6. On the following continuum of interdisciplinary collaboration ranging from coordination to integration, where do you place the chaplains in terms of participation?

Integration <--- Coordination

8 7 6 5 4 3 2 1

In order to help those interviewed to evaluate the degree of chaplain's participation as a team member, an integration-coordination scale was prepared. Each person interviewed was asked to rate on the scale the degree of chaplain's participation as a team member. Horwitz makes a distinction between integration and coordination. By integration he means the process in which the professional members of varied disciplines work interdependently and complementarily toward a common goal by communication and sharing of

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information. By coordination he means the process in which the professional members of varied disciplines work independently though relatedly with less communication and feedback to each other. Here I used integration and coordination as two opposite poles of the continuum. The continuum was scaled for rating purposes.

7. Which of the following clinical roles do you consider important for chaplains to fulfill as members of the interdisciplinary team?

   a. Participate in the staff conferences in planning, treatment and disposition of patients.

   b. Participate in diagnostic conferences.

   c. Participate in morning rounds.

   d. Participate in community meetings.

   e. Contribute as a primary therapist.

   f. Contribute to group therapy as a therapist or a co-therapist.

   g. Others: _____

On the final item the interviewees were asked to choose from a list of clinical roles those roles they felt it was important for chaplains to fulfill as team members.

METHOD

The author believed that a valid evaluation of the team participation of the chaplains must incorporate both self-evaluation by the chaplains and evaluation of the chaplains by other staff members. The information for evaluation was gathered by interviews based on a prepared question-

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naire (See Appendix D). The author evaluated himself by filling out this same questionnaire.

The staff members interviewed represented a variety of disciplines. They were selected at random from nine separate wards or programs. These staff members consisted of 4 psychiatrists, 3 social workers, 4 nurses, 2 pyschologists, 1 program director, and a human services worker. There were also 2 administrators and a librarian included in these interviews.

Six chaplains participated in the evaluation. These represented three full-time Protestant chaplains, two full-time Catholic chaplains and one part-time Jewish chaplain. Of these one Protestant chaplain devotes full-time to the outpatient community program. Two Catholic chaplains divide their time between inpatient and outpatient programs.

INTERVIEW RESULTS

1. To the question, "What is your concept of the role of a chaplain?, the following were some of the responses:

Staff members

a. A person who is a resource for the patient during his hospitalization, e.g., a sense of belonging to the alienated.

b. A person who can help the patient find a source of meaning and strength, who can help him integrate his early religious training with the adaptation to everyday living, especially in respect to guilt, and who can help him see that religion and psychotherapy are compatible.

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c. A person who can provide for the patient' spiritual need, fills the father-confessor's role and help resolve his religious hangups.

d. A person who provides therapeutic support by being available to discuss problems with the patient.

e. A person who administers religious services to the patient so he may continue his life style in the hospital uninterrupted, e.g., church attendance.

f. A person who revives and/or reaffirms life's values in the patient.

g. A person who helps the patient deal with conflicts through his expertise in both religion and psychology.

h. A good listener who represents God.

i. Someone who can give consultation to religious people; who can offer counseling and support; and who is familiar with community resources.

j. Someone who provides spiritual guidance and help during his illness and frustration and assists other professional staff by counseling.

k. Someone who can help the patients synthesize the things going on based on the religious background.

Chaplains

a. A person who provides pastoral support as a component of total patient rehabilitation.

b. A person who is a pastor, advocate to patient's right to receive help, counselor and resource person for emergency needs.

c. A nice guy.

d. A person who performs healing, sustaining, guiding functions by using spiritual resources.

e. A friend of the patient. He is in the institution but not of the institution.

f. A pastor to hospitalized patients. He is able to

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understand the role of other staff members, and to integrate his primary functions as pastor into a secondary function as a member of the ward treatment team, thus bringing the healing aspects of religion into the formal treatment program.

2. To the question, "Which of the following definitions of interdisciplinary team best fits your concept of interdisciplinary team approach?", the following responses were made:

a. A term which includes all who are actively engaged in promoting the health and welfare of the patient, such as doctors, nurses, administrators, dietitians, social workers, occupational therapists, etc.

b. A term to designate every member of the professional staff within a specific unit of the hospital.

c. The process whereby various professionals who make individual decisions concerning patients and who share a common purpose, meet together to communicate and share knowledge from which plans are made and thus future therapeutic decisions are influenced.

Responses: Three staff members picked (a), and 16 staff members picked (c). Two chaplains picked (a) and four chaplains picked (c),

3. To the question, "Do you consider the chaplains as members of the interdisciplinary team?", the following were the responses:

Responses: Seven staff members said "Yes," and nine staff members said "No." All six chaplains said "Yes."

4. To the statement, "If no, please give reasons," the following responses were given:

Staff members

a. Spread thin.

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b. Not visible.
c. We don't see enough of you guys.
d. Doesn't make himself available and visible.
e. Have not negotiated with us as to how many hours they can give.
f. No active part to play.
g. They do not have an ongoing relationship with the patient and the staff.
h. We don't know what they can do.

5. To the question, "Which of the following three types of interdisciplinary team do you consider the chaplains are members of?" the following were the responses:

a. Basic
b. Extended
c. Consultive

Responses: Among the staff members four selected (a), 11 selected (b) and eight selected (c). Among the chaplains one selected (a), four selected (b), and one selected (c).

6. To the question, "On the following continuum of interdisciplinary collaboration ranging from coordination to integration, where do you place the chaplains in terms of participation?", the following responses were given:

Integration <--- Coordination

8 7 6 5 4 3 2 1

Responses: Among the staff members the number of those who rated 1, 2, 3, 4, 5, 6, 7, and 8 were 3, 5, 6, 2, 2, 0, 1, and 0 respectively. The median score for the staff members was 2.9. Among the chaplains the number of those who rated 1, 2, 3, 4, 5, 6, 7, and 8 were 1, 1, 1, 2, 1, 0, 0, and o respectively. The median score for the chaplain was 3.2.

7. To the question, "Which of the following clinical roles do you consider important for chaplains to fulfill as members of the interdisciplinary team?", the following were

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the responses:

a. Participate in the staff conferences in planning, treatment and disposition of patients.

b. Participate in diagnostic conferences.

c. Participate in morning rounds.

d. Participate in community meetings.

e. Contribute as a primary therapist.

f. Contribute to group therapy as a therapist or as a co-therapist.

g. Others: _____

Responses: Among the staff members the number of those who picked a, b, c, d, e, f, and g were 13, 6, 3, 7, 4, 9, and 5 respectively. Among the chaplains the number of those who picked a, b, c, d, e, f, and g were 4, 5, 2, 3, 1, 4, and 0 respectively.

DISCUSSION

1. In general, the interview results indicate that the clinical staff members in particular see the chaplains in more specific roles than do the chaplains themselves.

2. Most of the staff members interviewed chose the third definition in harmony with their concept of interdisciplinary team. On the other hand, not all chaplains selected the third definition though there were twice as many over those who picked the first definition. This suggests that some chaplains are inclined to feel that they can function as team members without getting involved in staff meetings.

3. The clinical staff members who picked the third definition may be disposed to evaluate the chaplains in

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terms of what this definition implies. Whereas all chaplains saw themselves as members of the interdisciplinary team, more than half of the staff members did not consider the chaplains as such.

4. The reasons those who do not consider the chaplains as members of the team gave were based on the lack of interaction, communication and sharing of information. The three responses, however, which are believed to have some impact on the chaplains' endeavors to become members of the team are:

a. Have not negotiated with us as to how many hours they can give.

b. They do not have an ongoing relationship with the patient and the staff.

c. We don't know what they can do.

5. The majority of both the staff members and the chaplains felt that the chaplains belong to the Extended Team. An encouraging finding of the interviews was that there were some staff members who saw the chaplains as members of the Basic Team. This participation is accomplished by negotiation of the chaplains with the program directors.

6. The degree of interdisciplinary collaboration was shown to be low according to the ratings of both staff members and chaplains. The median scores were 2.9 and 3.2 respectively.

7. The staff members and the chaplains were in agreement with the selection of the first 4 clinical roles.

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These roles were:

> Participate in the staff conferences in planning, treatment and disposition of patients.
>
> Contribute to group therapy as a therapist or a co-therapist.
>
> Participate in diagnostic meetings.
>
> Participate in community meetings.

CONCLUSION

There were eight objections by the staff members which prevented the chaplains from being perceived as team members. These were: (1) Spread thin, (2) Not visible, (3) We don't see enough of you guys., (4) Doesn't make himself available and visible., (5) Have not negotiated with us as to how many hours they can give., (6) No active part to play, (7) They do not have an ongoing relationship with the patient and the staff., and (8) We don't know what they can do. The author believed these objections were significant and valuable in assessing the present mode of ministry and in developing a new mode of ministry. Based on the information obtained from these data, literature, and personal experiences, the author arrived at the following conclusions: (1) The chaplain should further expand his ministry into clinical roles.;(2) The chaplain should become an active member on the Extended Team by task negotiation with the team members on each ward.; (3) The chaplain should maintain a close working relationship with other team members

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for successful integration into the team by continuous personal and professional communication.; and (4) The chaplain should focus his mode of ministry to the tasks of the team.

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Chapter 6

CONSTRUCTION OF A CHAPLAIN'S MODE OF MINISTRY CONSISTENT WITH TEAM APPROACH

This chapter describes construction of a chapalin's mode of ministry consistent with interdisciplinary team approach. Such manner of ministry is believed to be best expressed within the framework of the five major tasks of a team, which are outlined below.[1]

The first step consisted of determining the manner in which the roles of the chaplain contributed to each of the five tasks of a team. The contributions on each task were then elaborated and expressed in more operational terms. By arranging his operations under these five categories, a chaplain can readily recognize the contribution each of his functions is making to each major task of the team.

The result of this present endeavor is the integrated structure of the chaplain's functions formed into a meaningful whole around the major tasks of the team. This may also be seen as the adaptation of the chaplain's operations to the tasks of the team.

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[1]David M. Dressler and Kermit B. Nash, "Project Team Organization and Its Application to Crisis Intervention," Community Mental Health Journal, X, 2(1974), 156-162.

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ESTABLISHMENT OF AN INTERPERSONAL RELATIONSHIP AND CRISIS INTERVENTION

The visiting function of a chaplain places him in an advantageous position for establishing a vital relationship with the patient. The establishment of this relationship begins with the initial visit the chaplain makes on a new patient within 48 hours of his admission, and the relationship is maintained and developed by regular visits thereafter. Some of these initial visits may develop into advanced pastoral counseling sessions when such services are called for.

Most of these initial visits are introductory in nature and generally short in duration, however, their importance cannot be overlooked. Often the patient is found in a state of crisis with the feeling of estrangement from self, others and God. Compounding this is the feeling of isolation from his loved ones, friends or familiar places, and things become worse when the patient is confined in a locked ward. In this situation the initial service a chaplain offers becomes invaluable in helping the patient to establish an interpersonal relationship and in setting the tone for the patient's reconciliation with himself and with God.[2] Inasmuch as the chaplain symbolizes the love and

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[2]Bobb G. McCombs, "The Unique Role of the Minister a a Member of the Healing Team" (unpublished MTh thesis, Southern Baptist Theological Seminary, 1959), 53-55.

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goodness of God, the attitude in which he approaches the patient at this point is crucial, as it will determine the effectiveness of his work for him.

Initial Visits

1. The foundation is laid for a growing therapeutic relationship as rapport is established.

2. Through disciplined listening-to and reflecting-back of the patient's feelings, catharsis of bottled-up emotions begins.

3. The chaplain acquires a tentative understanding of the patient's internal frame of reference - how life looks from within his personal world.

4. If continued counseling by the chaplain seems indicated, the appointment for the next session should be made at the conclusion of the initial visit.

5. The chaplain informs the patient of chaplain services, such as worship and communion services, etc.

Utilization of Chaplain's Cards

1. Each day the chaplain is provided with data cards of patients admitted during the previous day.

2. These cards contain pertinent information about the patient, such as his name, religious preferences, ward location, etc.

3. The chaplain makes visitation notes on these cards

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for future reference. Well-maintained cards are necessary for ongoing ministry to the patient.

4. Cards are divided among the six chaplains according to three major religions (Catholic, Protestant and Jewish), and according to assigned wards. The Protestant chaplain also takes the cards of patients who do not come under these three categories. For example, a Protestant chaplain may receive cards of non-religious-preferences patients admitted to his assigned wards.

Utilization of Patient's Medical Record

1. Generally called the patient's "chart", the medical record is kept on the ward.

2. It is a valuable resource for patoral care in helping the chaplain to understand the patient.

3. The Patient's Progress Notes, which include entries from all team members give the chaplain up-to-date information on changes in the patient's physical and mental condition.

4. The chaplain may enter pertinent information concerning his pastoral visits in the Progress Notes section.

5. Its utilization is a valuable means of communication with other staff members.

Utilization of Greeting Cards (4" X 5")

1. A new supply printed annually contains an appropriate

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message, a prayer (e.g. Francis of Assisi), a calendar, a worship schedule and a list of chaplain's names.

2. The chaplain leaves a calling card with each new patient on the initial visit.

3. For absent patients it serves as an announcement of the chaplain's attempt to see them.

ENCOURAGING CATHARSIS OF DISTURBED THOUGHTS AND FEELINGS

In the initial visits the chaplain should accept the patient as he is, without being judgmental. The unconditional acceptance and the nonjudgmental attitude are also the two important ingredients in pastoral counseling. Another dimension of God's love is expressed in his commitment to the patient. Beginning with the initial visit and in the following contacts the chaplain attempts to convey his commitment to provide a sustaining support to the patient.

In all these contacts he should show his concerns and care for him. The extent to which the chaplain can show intimacy and friendliness is the measure of his success in ministry.

The outcome of all these expression of love is the establishment of a trusting and loving relationship. In this kind of relationship the patient will see the chaplain as someone he can confide in, consequently the sharing of

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his disturbed thoughts and feelings becomes natural.

The elicitation of pertinent information from the patient may not be regarded as an immediate goal for the chaplain since this comes over a period of time as a by-product or result of a trusting relationship. However, in pastoral counseling sessions the expression of disturbed thoughts and feelings is encouraged and elicited in an atmosphere of acceptance so that catharsis may take place.

In sharing certain information with other team members the chaplain needs to use utmost discretion so confidentiality, privacy, and dignity of the patient is observed under all circumstances.

As chaplain gains a diagnostic impression concernning the nature of the patient's problems and the way in which his relationships are failing to meet his needs, the chaplain is able to discover the patient's resources for coping with his situation and help him to mobilize his strengths.

Diagnostic Contribution of Chaplain

1. The patient's religious history and ideation may help in drawing correct symptomatic, characterological and psychodynamic diagnostic conclusions.[3]

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[3]Leonart I. Stein and John R. Thomas, "The Chaplain as a Member of the Psychiatric Team," AMHC Forum, XXVII, 3(1975), 108-109.

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2. The chaplain can provide the team with information relative to religious preoccupation, religious guilt, and religious delusion which have diagnostic value.[4]

3. The chaplain who is acquainted with normative religious expression is in a position to make authoritative discrimination between normal and pathologic religious elements in the personality.[5]

4. The chaplain should understand that the psychotic in a severe anxiety state is constrained to construct "explanation delusions" of a religious nature to justify his deviant thinking and behavior.[6]

5. The chaplain should understand that the neurotic uses religion for the defensive mechanism of denial and regression.[7]

Regular Visits and Pastoral Counseling

1. In one-to-one relationship some patients will feel more comfortable and better able to share their thoughts and feelings with the chaplain.

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[4]Statement by Cyril Barnert, M.D., psychiatrist, in the lecture to the chaplains, Los Angeles, Califonria, August 17, 1978.

[5]Orville S. Walters, "Religion and Psychopathology," Comprehensive Psychiatry, V, 1(1964), 33-34.

[6]Ibid., pp. 29-30.

[7]J. E. Runions, "Religion and Psychiatric Practice," Canadian Psychiatric Association Journal, XIC, 1(1974), 84.

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Community Meetings and Group Counseling

1. The presence of the chaplain in groups encourages trust in each other, and facilitates sharing of feeling and experiences.

2. The sharing in the group not only has cathartic effects on the patient, but helps him establish wholesome relationships with others.

Communication of Information

1. The chaplain should make brief entries of pertinent information in the Patient's Progress Notes section of the medical record.

2. When information is obtained from a follow-up of referral, the chaplain is responsible to report back to the referring individual.[8]

3. The chaplain may communicate directly with other team members individually to share pertinent information about a patient, especially in emergency cases.

4. The chaplain should attend staff meetings as consultant in presenting and interpreting data on patient's religious history and ideation to the staff.[9]

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[8]Julian L. Byrd, "A Critique of Clinical Pastoral Education in M. D. Anderson Hospital" (unpublished STM thesis, Perkins School of Theology, 1963), p. 31.

[9]Stein and Thomas, pp. 108-109.

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REDUCTION OF SYMPTOMATIC DISTRESS

The decisions relative to the patient's medication and hospitalization for the management of symptomatic distress are made by the team in the staff meetings presided over by psychiatrists.

Although the use of medication and hospitalization are essential for the treatment of symptomatic distress, there are patients who will resist taking medication or accepting hospitalization for various reasons. Under these circumstances a chaplain can be of invaluable help to the team efforts through his symbolic role. If a trusting relationship has already been established, encouragement on the part of the chaplain will help the patient to have confidence in the judgment of the team.

In order for the chaplain to fulfill the advocate role efficiently, he needs to resolve within himself his attitude toward the place of medication in the managment of symptomatic distress. Definitely, the dispensing of medication is necessary to bring possible relief to the patient from symptoms, such as depression, suicidal ideation, hallucination, delusions, etc. Though chemotherapy has its place, it should not become the sole mode of treatment. The patient needs assistance from a variety of sources in learning coping mechanisms to face reality. The chaplain can contri-

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bute an additional demension to the team in meeting this task.[10]

Staff Meetings

When the chaplain attends staff meetings he becomes knowledgeable about the treatment plans for the patients. This makes it possible for him to cooperate intelligently with the rest of the team.

Pastoral Counseling

The chaplain offers supportive counseling to the patient so he can deal with symptomatic distress, such as depression, suicidal ideation, hallucination, and delusions by helping the patient to draw upon his religious and spiritual resources.

RESTORING WHOLESOME RELATIONSHIP WITH SIGNIFICANT OTHERS

A person who is suffering from fragmentation and estrangement needs to restore a healing relationship with significant people.[11] A chaplain is a significant person

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[10]Statement by Gerald Motis, Psychiatrist, in the lecture on psychosis to the seminarians, Los Angeles, California, January 9, 1979.

[11]Paul E. Johnson, "Religion and Psychotheraphy," Progress in Psychotherapy, V (1960), 203-204.

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because he represents the spiritual and religious values in his traditional and symbolic role. He projects a loving and protective father image, and through all his roles, functions, and tasks he endeavors to point to the loving Heavenly Father. The chaplain helps the patient build healthy human relationships so that he may come to a healthy relationship with God.[12]

A loving and trusting relationship with the chaplain, a significant person to the patient, will have restorative and therapeutic effects on him. This is even more true if the patient is someone who is deprived of meaningful relationships with significant persons, such as parents, spouse, other loved ones.

The patient will transfer the wholesome and rewarding relationships with the chaplain to other people in his life, and such experiences will facilitate his communication with others. In this respect the chaplain can play an important role in helping the patient to reestablish disrupted communicative networks. A person who is emotionally disturbed is unable to establish mutually need-satisfying relationships. To a painful degree he is blocked or crippled in his ability to love deeply.[13]

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[12]Earle T. McKnight, "A Chaplain Interprets His Work," Canadian Nurse, LVII, 12(1961), 1141.

[13]Howard J. Clinebell, Jr., Basic Types of Pastoral Counseling (Nashville: Abingdon Press, 1966), p. 45.

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The ultimate goal of his ministry is to introduce God, the most significant Person, to the patient. It is likely that there also would be a carry-over of his relationship with the chaplain to his relationship with God. In a positive relationship with God the patient may discover for the first time the experience of reconciliation with Him. When this takes place the chaplain has fulfilled his reconciling function.

Theologically, the relationship to God is basic in the person's relationships to self and to his fellow human beings. As these threefold relationships mutually affect each other, the reconciliation with God will help the patient in his reconciliation with self and with his fellow human beings.

Pastoral Counseling

The chaplain, through counseling, helps patients find release from the captivity of their neurosis, overcome their alienation, increase their capacity to love, and renew their relationships.[14] The chaplain does ministry and/ or counseling to relatives and friends in order to improve relationships of patients to these significant persons.

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[14]Ibid., p. 45.

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Communion Services and Worship Services

1. Participation in these services will help the patient enter into a meaningful experience with God.

2. Participation in these services will help patient to enter into the experience of reconciliation with God.

3. Holy communion service is a dramatic illustration of a community in fellowship with God and with one another.[15]

4. Participation in these services encourages the use of religious resources, such as prayer, scripture, etc. as a means of communion with God.

Community Care

Ministry to the outpatients is an integral part of the Chaplain Service. The ministry to the patients does not end when they leave the hospital. The chaplain continues to show interest and care for their well-being, and makes himself available in whatever ways possible, especially with outpatients who periodically return to the hospital for medication or/and other appointments.

DEVELOPING SUCCESSFUL COPING MECHANISMS

Basic to the learning of coping mechanism for

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[15]Taylor D. Neely, "A Pastoral Ministry in a Mental Hospital," Medical Annals of the District of Columbia, XLI, 8(1972), 521.

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handling future stressful situations is the ability to deal with negative feelings with awareness, honesty and self-acceptance so to own them.

The growth in such ability is believed to take place best in an atmosphere in which nonjudgmental attitude and acceptance prevail, and feelings and experiences are freely shared. The chaplain with some degree of pertinent training is best equipped to create such an atmosphere because of his traditional and symbolic roles.

It is primarily to structure this kind of setting that a one-to-one session or small group sessions are conducted. This is where patients are given the opportunity to grow. Thus, the chaplain "with empathy and pastoral concern, ... stays with and assists the patient to work through his present stress by understanding himself, the ultimate meaning of his present sickness for himself, and effecting within himself, with other selves and with God a personal reconciliation and change that bring about healing and growth in the whole patient."[16] In the case of small group sessions, the chaplain may either lead or co-lead depending on the circumstances.

In the performance of his roles, tasks, and functions, the chaplain makes another important contribution to

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[16] Harshajan Pazhayatil, Counseling and Health Care (Chicago: Franciscan Herald Press, 1977), p. 49.

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the fifth task of the team. That is, in whatever forms he revives or reinforces trust in God in the patient, he is adding another dimension to the patient's coping mechanism for handling future stressful situations. Inasmuch as an abiding trust in God gives a person the assurance of divine help and care, a patient with the consciousness of divine support is also on advantageous ground to deal with stressful situation because of his increased ability to trust other persons.

The chaplain helps the patient deal with crisis problems by developing new, socially acceptable, reality-based problem-solving techniques which add to his capacity to deal in a healthy way with future difficulties.

The new pattern of coping that he works out in dealing with crises becomes an integral part of his repertoire of problem-solving responses.

Poole's statement well summarizes the contribution of chaplains to this task of the team:

> The clergyman is in an excellent position to contribute to ego strength, security, trust, and constructive living; and as such, should be an indispensable member of the healing team.[17]

Pastoral Counseling

According to Clinebell, "Pastoral counseling is the

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[17]Robert Poole, "Medicine and Religion," Pennsylvania Medicine, LXXI, 3(1968), 62.

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utilization , by a minister, of a one-to-one or small group relationship to help people handle their problems of living more adequately and grow toward fulfilling their potentialities. This is achieved by helping them reduce the inner blocks which prevent them from relating in need-satisfying ways."[18]

The use of supportive counseling can be of major help to a patient by steering him away from maladaptive responses and toward a constructive facing of his crisis. The seven methods of supportive counseling suggested by Clinebell are:

1. Gratifying dependency needs. The chaplain communicates caring for a troubled person by comforting, sustaining, feeding (emotionally), inspiring, guiding, protecting, instructing, and setting dependable limits.

2. Emotional catharsis. Pouring out one's feelings in an understanding and accepting relationship frees one from paralyzing tensions so he regains objectivity and use of problem-solving abilities.

3. Objective review of the stress situation. The supportive relationship allows the patient to review his stressful situation with some objectivity.

4. Aiding the ego's defenses. This is the opposite of uncovering, confronting, or probing.

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[18]Clinebell, p. 20.

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5. Changing the life situation. The chaplain may either help the patient change, or arrange to have change, the circumstances (physical, economic, or interpersonal) which are producing debilitating disturbances and frustrations in his life.

6. Action therapy. The chaplain encourages the patient to do something about his situation.

7. Using religious resources. Prayer, scripture, and devotional literature are valuable supportive resources.[19]

Criteria for Evaluating Pastoral Counseling

1. How well does the counseling help persons increase their ability to relate in ways that satisfy his basic personality needs?

2. How well does the counseling help persons to handle their load of problems and responsibilities?

3. How well does the counseling help persons to continue to grow toward the fulfillment of their unique personhood?

4. How well does the counseling help persons to develop constructive relationships?

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[19] Ibid., p. 141-44.

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5. How well does the counseling help persons' relationship with God to become increasingly meaningful?

6. How well does the counseling help persons to become a renewal agent in their family, community, and Church.[20]

As a fully accepted member of the clinical treatment team the chaplain making the fullest possible contribution will be expected to fulfill the above criteria in providing pastoral counseling.

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[20]Ibid., p. 20.

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Chapter 7

CONCLUSION

The purpose of the author's study was to evaluate the chaplain's present mode of ministry at the VA Medical Center, Brentwood in order to construct a more effective mode of ministry consistent with interdisciplinary team approach.

The physical facility and the present mode of ministry at Brentwood tend to isolate the chaplain from the heart of the patient's treatment programs and from other professional team members. It was assumed by the author that the chaplain may best fulfill his chaplain's role when he participates significantly as a member of the interdisciplinary team. These situations prompted the author to undertake this study.

Of the literature reviewed, those which provided the study with significant background information were categorized under 1) organization and functions of interdisciplinary team and 2) role-functions of the chaplain. Studies in the first category provided information on criteria for, and types of, interdisciplinary team, and information on three prerequisites for effective team development, which all helped to evaluate and improve on the present status of chaplain's team participation at Brentwood. In the second categegory studies described the prevalence of misunderstanding

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and stereotyped view of chaplain's role-functions by the staff and patients in clinical situations, and the influence of role-expectations of the chaplain by the administrator on chaplain's role functions. These studies indicated the need for chaplain to reassess his mode of ministry, and suggested that the chaplain needs to function broadly in an integrated way as a team member by including both traditional and nontraditional roles in his mode of ministry. In addition, one study emphasized the fact that the chaplain's contributions to the treatment program can be most significant when he is a full participant on the team.

Next, the potential of the chaplain to participate on the team was investigated. Since the 1930's psychiatric teams have developed steadily in this country. The value of employing psychiatric teams has been demonstrated over the past five decades, and studies of psychiatric teams have had far-reaching professional and social significance in the staffing of psychiatric hospitals and clinics.

The concept of psychiatric teams in the United States developed at a time when varied clinical professionals were struggling to achieve identity and recognition. Clergymen were, therefore, not usually accepted by these disciplines as being on their peer level, and were not included as team members. However, the author found out that today the climate for clergymen's participation as team members is much more favorable for the following reasons: (1) the improvement of

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medico-clerical cooperation, (2) trend toward holistic approach, (3) establishment of community mental health centers, and (4) growth of clinical pastoral education.

The potential of the chaplain's participation on the team was further investigated by considering the types of teams, characteristics of teams, composition of team, major tasks of teams and, additionally, structure of teams as described in literature and as they actually are at Brentwood. The author concluded from this investigation that at Brentwood (1) there is a definite need and place for the chaplain on the team, (2) the chaplain can serve best as a member of the Extended Team, and (3) he can make significant contributions to the tasks of the team.

This was followed by assessing the feasibility of the chaplain's role adaptation at Brentwood by considering some of the factors which influence the capabilities of the chaplain to function as a team member. These factors were: (1) the chaplain's orientation in terms of traditional vs. clinical roles; (2) organizational structure of the totol institution; (3) attitudes of the administration, staff, and patients; (4) the chaplain's qualifications, and training, and his working and social relationships to other professional staff members. The assessment based on these factors has helped the author to arrive at the following conclusions:

(1) The chaplain's function ought to encompass both traditional and clinical roles to broaden his ministry.

(2) Though the physical facility which consists of

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multiple buildings and multi-ward organizational structure keeps the chaplain from becoming a member of Basic Teams, he can function as a member on the Extended Teams.

(3) It will help the chaplain to function on an equal par with other clinical professional members if the positioning of the Chaplain Service on the organizational chart was moved to the Chief of Staff's jurisdiction.

(4) In order to overcome the misunderstanding and stereotyped view of chaplain's role-functions by the staff and patients, the chaplain must negotiate his clinical roles with the members of the Extended Team on each program. (The program director may be considered the administrator.)

(5) The chaplain should find it possible to work with other members of the team by being able to enter into interdependent peer relationships.

(6) The chaplain should have some clinical pastoral education or its equivalent in experience.

(7) The chaplain should maintain a close working relationship with other team members for successful integration into the team by continuous personal and professional communication.

In connection with this study a theology of ministry was developed. The chaplain should realize the uniqueness of his role as a chaplain and should make his ministry relevant to the patients of contemporary society. The author believed that this could be done only as his ministry has a solid Biblical and theological basis.

Next, the present status of the chaplain's team participation at Brentwood was evaluated with data gathered by interviewing randomly selected staff members and all chaplains, using a questionnaire. Based on the information obtained from these data, literature, and personal experiences, the author arrived at the following conclusions: (1) The

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chaplain should further expand his ministry into clinical roles. (2) The chaplain should become an active member on Extended Team by task negotiation with the team members on each ward. (3) The chaplain should maintain a close working relationship with other team members for successful integration into the team by continuous personal and professional communication. (3) The chaplain should focus his mode of ministry to the tasks of the team.

Finally, a new chaplain's mode of ministry was constructed around the five tasks of the team based on the evaluation of the present mode of ministry. The author believes that this new mode of ministry will help the chaplain to meet the challenge of his work as an integral member of the team in advancing the mission of the VA Medical Center, Brentwood.

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APPENDIX

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APPENDIX A

PROGRAM SURVEY COMPILED BY EVALUATION/ADMISSION SERVICE — February 1976

UNIT I

210A

30 Beds, Male.
Dr. Roncal; Dr. Hanesn;
No Resident
-General psychiatry; eclectic, multimodality.
-Two staff teams, each M.D. responsible for one team, separate and combined treatment activities.
-Prefer balanced patient population.

210C

30 Beds, Male and Female.
Dr. Van Putten; 2 Residents
-Long-term research project on antipsychotic medication. Overall program; eclectic, multimodality.
-Preferred admissions: Diagnosis of schizophrenia, willing to take medication, not requiring long-term placement.

256A

30 Beds, Male.
Dr. Martin; Dr. Saunders;
1 Resident.
-General psychiatry; eclectic, multimodality; emphasis on psychodynamic insight-oriented open milieu.
-Joint supervision by both M.D.'s.
-Prefer balanced patient population.
-Primary ward for AD-ASMRO.

UNIT II

206A

20 Beds, Male.
Dr. Zirgulis; No Resident.
-General psychiatry; eclectic, multimodality; conservative use of medication.
-Prefer balanced patient population.
-Some therapeutic activities shared with 206B and 206C.

206B

20 Beds, Male.
Dr. Sabaratnam, No Resident.
-General psychiatry: eclectic, multimodality.
-Prefer balanced patient population. Some therapeutic activities shared with 206A and 206C.

206C

20 Beds, Male.
Dr. Reif, No Resident.
-General psychiatry; eclectic multimodality; more liberal use of medication. Some therapeutic activities shared with 206A and 206B.

206D

20 Beds, Male.
Dr. Lansky, 1-2 Residents.
-Family oriented treatment program, utilizing traditional and family therapy approches.
-Admission criteria:"Family" related problems, availability of family members to participate in treatment program.
-Actively transfers suitable patients from other wards.

UNIT III

205A

32 Beds, Male and Female.
Dr. Lundgren, 1-2 Residents.
-General psychiatry, multimodality, with emphasis on psychoanalytic group process, in an open milieu.
-No specific admission criteria, but prefer actively psychotic patients.

205D

20 Beds, Male.
Dr. Gosenfeld, No Resident.
-General psychiatry, with token economy milieu; multimodality. Special interests: behavioral treatment programs, pharmaco-therapy.
-Admission Criterion: 30 years of age, or younger.
-Ward is closed as part of token economy program, not for general restraint.
-Prefer patients with acute psychotic illnesses.

UNIT IV

207A

20 Beds, Male.
Dr. Gross, 1 Resident.
-General psychiatry; eclectic, multimodality; liberal use of medication.
-Prefer balanced patient population.

207B

20 Beds, Male,
Dr. Poliquin, No Resident.
Geriatric Psychiatry
-Admission criteria: 60 years of age or older, (some exceptions) with acute or recent onset of psychiatric symptoms other than CMS; not requiring chronic-care placement, or medical hospitalization.
-Eclectic, multimodality treatment program.

207C

20 Beds, Male.
Dr. Glick, 1 Resident.
-General psychiatry, eclectic, multimodality.
-Prefer balanced patient population.

207D

20 Beds, Male.
Dr. Barnett, 1 Resident.
Admission criterion: 30 years of age, or younger.
-General psychiatry; eclectic, multimodality treatment prog. for young patients including combat-related problems.
-Prefer acute illnesses, balanced patient population.

APPENDIX A

PROGRAM SURVEY COMPILED BY EVALUATION/ADMISSION SERVICE

Unit V 257A	Unit V 257B	Unit V 257C	Medical Service 208-2W
(Combined Alcohol & Drug Prog.("D.A.R.U.") 20 Beds, Male. Dr. Schlesinger; Dr. Friedman, No Resident. -Inpatient and outpatient (aftercare). -Patients requesting inpatient treatment for drug abuse will be evaluated by D.A.R.U. staff to determine eligibility, screening daily (weekdays). -Status of screening for inpatient alcohol abuse program: Patients currently screened by 257A on referral from E/A. (Direct admission by E/A may be implemented after transition period of ward reorganization).	Outpatient Drug Abuse Program (DTP) and TAC (Total Abstinence Colony). -No inpatient beds. -Dr. Charuvastra and Dr. Barakonski. -Patients requesting outpatient treatment for drug abuse will be evaluated by DTP staff. No direct admissions from E/A Service. -Outpatient programs include methadone maintenance and drug-free program. -Generally will not accept patients with other significant psychiatric symptomatology. Screening daily (weekdays). "ASMRO" patients (active duty) are screened by DTP on arrival (weekdays), or admitted overnight on inpatient wards (evenings, weekends) for DTP screening next weekday.	-"A.T.P." - (Alcohol Treatment Program). -40 Beds, Male, 4 Acute detox beds. -Dr. Lowenstam, Dr. Katz, No Resident. -Highly structured inpatient and outpatient (aftercare program, emphasizing group activities, educational techniques, antabuse maintenance. -4 week inpatient program, 1 year OPT follow-up. -Excludes: Acute psychosis unrelated to alcohol, severe medical or psychiatric problems, chronic ONS, significant cardiovascular disease or uncontrolled hypertension (contraindications to antabuse); placement needs; patient who has not worked at all during previous year. -Patients are admitted directly through E/A Service or by ATP staff (through direct referral from community). -Admission to detox beds based on bed availability and expectation that patient is appropriate for program. -ATP will accept their OPT patients for brief detox up to four times per year. -If a patient is accepted, but no bed is available, future admission can be pre-arranged.	24 Beds, Male, 1 Isolation Bed. -Dr. Zweig, Dr. Flores, Dr. Segal, Dr. Olick -Primary medical coverage for Brentwood patients. -Inpatient and outpatient care. -Handles general medicine, other than cardiac emergencies; no surgical specialties. -Accepts patients on transfer from inpatient psychiatric wards. -Patients directly admitted if appropriate medical problem is the primary basis for admission. Cannot handle severely disturbed patients. Patients are not admitted to the Medical Service for acute intoxication unless treatment is indicated for impending DT's or barbiturate withdrawal, or for further medical follow-up if indicated, after initial treatment at Wadsworth for drug overdose. 25BE Designation for use of one to three beds housed on 208-2W, but under the responsibility of the E/A Service, which can be used for overnight hospitalization pending further evaluation.

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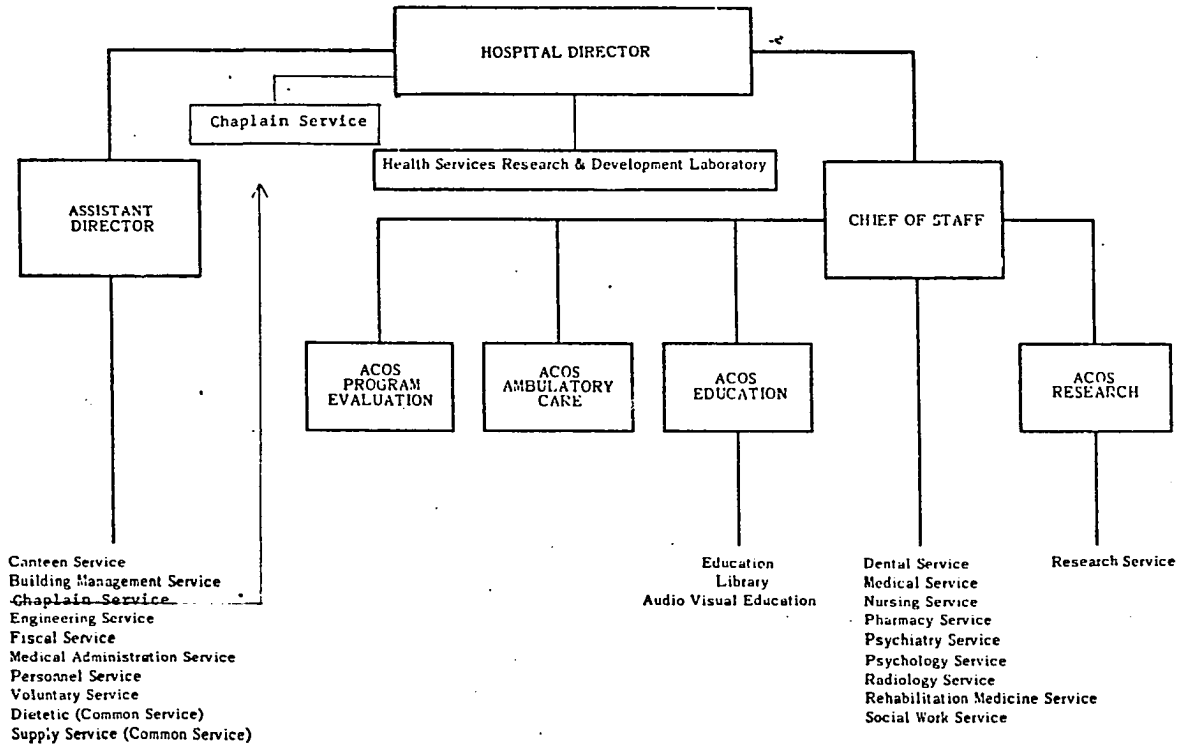
APPENDIX B

VA HOSPITAL BRENTWOOD

LOS ANGELES, CALIFORNIA



APPENDIX C

DESCRIPTION OF INTEGRATION AND COORDINATION

INTEGRATION

1. Resultant assessment may be synthetic. Bits of data and partial insights are integrated into one cohesive overview as the outcome of a discussion.
2. Operations are conjoint and continual, and there is frequent sharing or feedback of data.
3. There are more communicative transactions with information verification and correction (feedback).
4. Action taken by the team as a unit might more likely be of informally achieved consensus. There is a tendency to plan the service process as essentially a group undertaking from start to finish with no problem the exclusion concern of one member.
5. Each member functions interdependently of other members. Truly engaged in the group each member does his work as an integral part of the work of every other members. The activities of each member interpenetrate those of others.
6. There is a concordance of tempos in team process. With pervasive patterns of synchronized interactions the work schedule of all becomes the work schedule of each.

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COORDINATION

1. Diagnosis may be additive. Each member makes a discrete, segmental contributions.
2. Operations which are successive or simultaneous are independent though related.
3. There is less communication, which means less information verification and correction (feedback).
4. Action taken by the team as a unit might more likely be the outcome of a voting process.
5. Services offered by the disciplines are independent, and provided in what is basically a confederated milieu.
6. Task performance would in most cases be in parallel, and consultations would commonly be formally arranged.
7. The autonomy of each worker within some defined practice area would be more jealously guarded. May from day to day provide for very ample sharing of the work among like-minded, similarly involved colleagues without compromising the autonomy of any.
8. Team structure guarantees some concodance in essentially independent service processes.

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APPENDIX D

INTERVIEW QUESTIONNAIRE

1. What is your concept of the role of a chaplain?

2. Which of the following definitions of interdisciplinary team best fit your concept of interdisciplinary team approach?

   a. A term which includes all who are actively engaged in promoting the health and welfare of the patient, such as doctors, nurses, administrators, dietitians, social workers, occupational therapists, etc.

   b. A term to designate every member of the professional staff within a specific unit of the hospital.

   c. The process whereby various professionals who make individual decisions concerning patients and who share a common purpose, meet together to communicate and share knowledge from which plans are made and thus future therapeutic decisions are influenced.

3. Do you consider the chaplains as members of the interdisciplinary team?

   YES_____ NO_____

4. If no, please give reasons.

5. Which of the following three types of interdisciplinary teams do you consider the chaplains are members of?

   a. Basic
   b. Extended
   c. Consultive

6. On the following continuum of interdisciplinary collaboration ranging from coordination to integration, where do you place the chaplains in terms of participation?

   Integration ← Coordination

   8 7 6 5 4 3 2 1

7. Which of the following clinical roles do you consider important for chaplains to fulfill as members of the interdisciplinary team?

   a. Participate in the staff conferences in planning, treatment and disposition of patients.

   b. Participate in diagnostic conferences.

   c. Participate in morning rounds.

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d. Participate in community meetings.

e. Contribute as a primary therapist.

f. Contribute to group therapy as a therapist or a co-therapist.

g. Others:

_____

_____

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